

Instructions for Completing the HealthSystems of Mississippi Additional Medical Information Form

NOTE: The Additional Medical Information Form serves two purposes: 1) Serves as an **attachment** to the Admission Review Form or Concurrent Request Form when additional space is needed, 2) Serves as an HSM form to submit requested additional information required to complete the review process. *Re-submission of the Admission Review Form or Concurrent Review Form is not necessary.*

Section I Beneficiary Information

1. **Beneficiary Medicaid #** - Enter the beneficiary's number that appears on the MS Medicaid ID card.
2. **Beneficiary Name** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card.
3. **Date This Information Submitted** - Enter the date in which you submit additional information.
4. **Admit Date** - Enter the actual admission date.

Section II Provider Information

1. **Facility MS Medicaid #** - Enter the facility's Mississippi Medicaid provider number.
2. **Facility Name** - Enter the name of the facility that will render the treatment.
3. **Requester Name** - Enter the name of the individual requesting the review.
4. **Requester Tel #** - Enter the telephone number of the requester including area code and extension number.

Section III Additional Medical Information

1. **Information Requested by** - Enter the name or number of the HSM reviewer that requested the additional information (if applicable).
2. **Additional Medical Information** - Enter all information requested and any additional supporting documentation to support the medical necessity for certification.