HealthSystems of Mississippi
Additional Medical Information Form

BENEFICIARY INFORMATION	PROVIDER INFORMATION
Beneficiary Medicaid #: _____ Beneficiary Name: _____ Date This Information Submitted: _____/_____/_____ Admit Date: _____/_____/_____	Facility MS Medicaid #: _____ Facility Name: _____ Requester Name: _____ Requester Tel #: (_____) _____-_____ Ext. _____

Information Requested by: *(if applicable)* _____

(HSM Reviewer Name / Number)

ADDITIONAL MEDICAL INFORMATION

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MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

HEALTHSYSTEMS OF MISSISSIPPI'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.