

# Instructions for Completing the HealthSystems of Mississippi Medicaid Psychiatric Residential Treatment Facility Precertification Plan of Care Review Form

## Section I Beneficiary Information

1. **Beneficiary Name** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card.
2. **Beneficiary Medicaid #** - Enter the beneficiary's number that appears on the MS Medicaid ID card.
3. **Date of Birth** - Enter the month, date, and year of the beneficiary's birth. (Use two-digit numbers).
4. **Sex** - Indicate the sex of the patient.
5. **Age** - Enter the age of the beneficiary at the time service is to be rendered.

## Section II Provider Information

1. **Provider MS Medicaid #** - Enter the provider's Mississippi Medicaid number ID.
2. **Provider Name** - Enter the name of the provider that will render the treatment.

## Section III Request Information

1. **Request Date** - Record the date of the request.
2. **Requested By** - Indicate whether the physician or facility made the request.
3. **Requester's Name** - Enter the name of the individual requesting the review.
4. **Requester's Tel #** - Enter the telephone number of the requester including area code.
5. **Physician Name** - Enter the name of the physician rendering the service.
6. **Physician MS Medicaid #** - Enter the physician's Mississippi Medicaid provider number.
7. **Physician Address** - Enter the address of the physician rendering the service.
8. **Physician Tel #** - Enter the telephone number of the physician rendering the service.

## Section IV Medical Information

1. **Planned Date of Admission** - Enter the proposed admission date.
2. **IQ** - Enter the beneficiary's IQ score.
3. **Diagnoses/ICD-9-CM Codes** - Enter the beneficiary's current diagnoses (five parts of multi-axial) and enter the ICD/9-CM codes that correspond with the diagnoses.
4. **Location and Distance** - List the county and state the beneficiary resides, and the approximate distance the family member must travel to the facility for family sessions.
5. **Clinical Signs and Symptoms** - List clinical signs/symptoms that are present at admission.
6. **Objectives** - List the objectives and anticipated accomplishments of the treatment.
7. **Previous Admissions** - List all admissions within the last six (6) months for psychiatric treatment. Include shelters, group or foster homes, detention centers, training schools or outpatient therapy.
8. **Explanation of Alternative Setting** - List why the patient could not be treated in another setting (lower level). The physician must provide input and sign/date the explanation.

\* **A copy of the independent evaluation completed by a psychiatrist or psychologist, which indicates the need for psychiatric residential treatment, and the potential for benefit from psychiatric residential treatment must be attached to this form. This evaluation must be performed within the last 60 days prior to the proposed admission date.**

\* **For certification review on retroactively eligible Medicaid beneficiaries, a copy of the psychiatric evaluation completed on admission is required.**