

# HealthSystems of Mississippi Medicaid Psychiatric Residential Treatment Facility Precertification Plan of Care Form

\* This form should accompany all psychiatric residential treatment precertification requests (three working days prior to admission). \*

BENEFICIARY INFORMATION	PROVIDER INFORMATION
Beneficiary Name: _____	Provider MS Medicaid Number: _____
Beneficiary Medicaid #: _____	Provider Name: _____
Date of Birth: ____/____/____	
Sex: ____ (M or F)      Age: _____	

## REQUEST INFORMATION

Request Date: \_\_\_\_/\_\_\_\_/\_\_\_\_      Requested By:     Facility                       Physician

Requester's Name: \_\_\_\_\_ Requester's Tel #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician MS Medicaid #: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician's Tel #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

## MEDICAL INFORMATION

Planned Date of Admission: \_\_\_\_/\_\_\_\_/\_\_\_\_      IQ: \_\_\_\_\_

DIAGNOSIS (List five parts of multi-axial diagnosis )	ICD-9-CM CODES
I.	
II.	
III.	
IV.	
V.	

List the county and state the beneficiary resides and the approximate distance the designated family member must travel to the facility for family sessions: \_\_\_\_\_

**HealthSystems of Mississippi Medicaid  
Psychiatric Residential Treatment Facility  
Precertification Plan of Care Form**

**Beneficiary Name:** \_\_\_\_\_ **MS Medicaid #:** \_\_\_\_\_

Clinical Signs and Symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What objectives will be met during this admission: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any previous admissions (to any provider) in the past 6 months: \_\_\_\_\_

*Please include shelters, group or foster homes, detention center, training schools or outpatient therapy.*

Please provide a detailed explanation why the beneficiary could not be treated in alternative settings:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Attending physician's signature

\_\_\_\_\_  
Date

- \* 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.

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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.**