

**Instructions for Completing the HealthSystems of Mississippi
Medicaid Psychiatric Residential Treatment Facility Concurrent 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 beneficiary.
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 ID number.
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. **Date of Admission** - Enter the date of admission.
2. **Number of Additional Days Requested** - Enter the number of additional days requested.
3. **Last Date Certified** - Record last review date.
4. **Treatment Authorization Number** - Enter certification number issued at last review.
5. **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.
6. **Medical Information Dates** - Enter the from and through dates for the medical information accompanying the concurrent review request.
7. **Description of Current Behavior** - List the present condition (including the behavior and symptoms) of the beneficiary as it relates to the current diagnoses.
8. **Complications** - List any complications that have occurred since this admission.
9. **Changes in Treatment Plan** - List changes in treatment including any new medications, special procedures and family treatments initiated after admission.
10. **Discharge Plans and Aftercare Plans** - List discharge plans that have been initiated.
11. **Discharge Problems** - List problems that have occurred which are interfering with discharge planning.
12. **Explanation of Alternative Setting** - List why the beneficiary could not be treated in another setting (lower level). The physician must provide input.