

HealthSystems of Mississippi Out-of-State PRTF Referral Form

**This form should accompany all psychiatric residential treatment precertification requests (seven days prior to admission). A separate form must be completed by each in-state facility that offers the necessary specialized program required.*

PATIENT INFORMATION

Beneficiary Name: _____

Beneficiary Medicaid #: _____

Date of Birth: ____/____/____ Sex: ____ (M or F)

THIS SECTION TO BE COMPLETED BY THE OUT-OF-STATE FACILITY

Out-of-State Facility Name: _____

Contact Name: _____

Contact Tel #: (____) ____ - ____ Ext. _____

What is your understanding of the patient's presenting problem? _____

Is the necessary service(s) available within the state of Mississippi? No Yes

Is the patient being admitted to a PRTF directly from an acute care setting? No Yes

If yes, give the name of the facility: _____

THIS SECTION TO BE COMPLETED BY THE IN-STATE FACILITY

Referring Facility Name: _____

Contact Name: _____

Contact Tel #: (____) ____ - ____ Ext. _____

What is the status of the current request for service(s) by the in-state facility? Approved or Denied

If denied, what was the reason for the denial? (i.e. specialized need(s), no bed available) _____

If the patient has specialized need(s), describe in detail (i.e. sex offender, lower than average IQ, hearing impairment):

Does your facility have a program to meet the specialized need(s) of this patient? No Yes

If yes, do you currently have a bed available? No Yes

If no, when do you anticipate a bed becoming available? _____

Contact Signature _____ Date _____

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