

**Instructions for Completing the HealthSystems of Mississippi Medicaid
Swing-Bed Precertification Request Form**

Section I Beneficiary Information

1. **Beneficiary Medicaid #** - Enter the beneficiary's number that appears on the MS Medicaid ID card.
2. **Beneficiary Name** - Enter the beneficiary's last and first name as it 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. Enter in months if less than two (2) years of age.
6. **Patient Account Number** - Enter the beneficiary's hospital account number. (*Optional field for hospital use only*)
7. **Is Medicare primary payer?** - Indicate whether Medicare is primary payer. If reply is yes, indicate if all Medicare benefits are exhausted.

Section II Provider Information

1. **Facility MS Medicaid #** - Enter the facility's Mississippi Medicaid provider number.
2. **Facility Name** - Enter the name of the facility that will render the treatment.
3. **Physician Name** - Enter the name of the physician rendering the service, first and last name.
4. **Physician MS Medicaid #** - Enter the physician's Mississippi Medicaid provider number.
5. **Requested By** - Indicate whether the physician or facility made the request.
6. **Requester Name** - Enter the name of the individual requesting the review.
7. **Requester Tel #** - Enter the telephone number of the requester including area code and extension number.

Section III Admission Information

1. **Request Date** - Enter the date that you submit your request.
2. **Admit Date** - Enter the actual admission date.
3. **Discharge Date** - Enter the discharge date if the beneficiary has been discharged from the facility.
4. **Proposed Admission Date** - Enter the date that the beneficiary is scheduled for admission. Include only when requesting precertification of an admission.
5. **Number of days requested** - Enter the anticipated length of stay.

Section IV Medical Information

1. **Level of Care** - Indicate what level of swing-bed care is needed.
2. **Diagnoses/ICD-9-CM Codes** - Enter the beneficiary's primary diagnosis and secondary diagnoses that relates to the necessity of swing-bed services and enter the ICD-9-CM codes that correspond with the diagnoses.
3. **Justification for Swing-Bed** - List the reason why swing-bed service is necessary, including activities requiring daily living assistance.