

HealthSystems of Mississippi Medicaid Swing-Bed Precertification Request Form

BENEFICIARY INFORMATION	PROVIDER INFORMATION
Beneficiary Medicaid #: _____	Facility MS Medicaid #: _____
Beneficiary Name: _____	Facility Name: _____
Date of Birth: ____/____/____	Physician Name: _____ (first) (last)
Sex: ____ Age: ____	Physician MS Medicaid #: _____
Patient Account #: (if applicable): _____	Requested By: <input type="checkbox"/> Facility <input type="checkbox"/> Physician
Is Medicare the beneficiary's primary payer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Requester Name: _____
If yes, are all Medicare benefits exhausted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Requester Tel #: (____) ____ - ____ Ext. ____

ADMISSION INFORMATION

Request Date: ____/____/____ Admit Date: ____/____/____ Discharge Date: ____/____/____

Proposed Admission Date: ____/____/____ (include only when requesting precertification of an admission)

Number of days requested: _____

MEDICAL INFORMATION

What level of care does the beneficiary require? skilled intermediate

DIAGNOSES (List diagnoses associated with reasoning for swing-bed)	ICD-9-CM CODES
1.	
2.	
3.	
4.	

Justification for Swing-Bed (include list of activities of daily living with which assistance is required, all deficits, treatment plan): _____

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