HealthSystems of Mississippi Medicaid
Swing-Bed Concurrent Certification 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: ☐ Facility ☐ Physician
	Requester Name: _____
	Requester Tel #: (_____) _____-_____ Ext. _____

CONCURRENT REVIEW INFORMATION

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

Last Date Certified: _____/_____/_____ Treatment Authorization # (TAN): _____

Number of additional days requested: _____

MEDICAL INFORMATION

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

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

_____

_____

_____

_____

_____

If level is intermediate, are you seeking nursing home placement? ☐ Yes ☐ No If no, please comment:

_____

_____

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