

**Instructions for Completing the HealthSystems of Mississippi Medicaid
Quality Re-review Request Form**

Section I Beneficiary Information

1. **Beneficiary Medicaid #** - Enter the beneficiary's last and first name as it 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 patient.
5. **Age** - Enter the age of the beneficiary at the time service is to be rendered.

Section II DME Provider Information

1. **DME Provider MS Medicaid Number** - Enter the DME provider's Mississippi Medicaid provider number.
2. **DME Provider Name** - Enter the name of the DME 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 DME provider made the request.
3. **Requester Name** - Enter the name of the individual requesting the review
4. **Requester Tel #** - Enter the telephone number of the requester including area code.
5. **Physician/Physician Assistant/Nurse Practitioner Name** - Enter the name of the physician, physician assistant, or nurse practitioner rendering the service.
6. **Physician/Physician Assistant/Nurse Practitioner MS Medicaid #** - Enter the physician/physician assistant's/nurse practitioner's Mississippi Medicaid provider number.

Section IV Quality Re-review Information

1. **Date of Quality Issue Notification** - Enter the date quality letter was issued.
2. **Date of Service** - Enter the date service began if applicable.
3. **Rationale for Request** - Enter the medical basis/rationale for disagreement.
4. **Additional information submitted** - Indicate whether additional information was submitted with the request.