HealthSystems of Mississippi Medicaid
Quality Re-review Request Form

BENEFICIARY INFORMATION	PROVIDER INFORMATION
Beneficiary Medicaid #: _____ Beneficiary Name: _____ Date of Birth: ___/____/____ Sex: ____ (M or F) Age: _____	DME Provider MS Medicaid #: _____ DME Provider Name: _____

REQUEST INFORMATION

Request Date: _____/_____/_____
Requested By: ☐ DME Provider ☐ Physician/Physician Assistant/Nurse Practitioner
Requester Name: _____
Requester Tel #: (____) _____-_____ Ext. _____
Physician/Physician Assistant/Nurse Practitioner Name: _____
(First) (Last)
Physician/Physician Assistant/Nurse Practitioner MS Medicaid #: _____

QUALITY RE-REVIEW INFORMATION

Date of quality issue notification: ____/____/_____ Date of Service: _____/_____/_____
Rationale/medical reason for disagreement: _____

_____

_____

_____

_____

_____

_____

Is additional information being submitted? ☐ Yes ☐ No

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

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