HealthSystems of Mississippi Medicaid
Home Health Certification Review – Reconsideration Request Form

I. BENEFICIARY INFORMATION

PATIENT INFORMATION	K-BABY -CHECK BOX AND COMPLETE BELOW:
Patient/Baby Name: _____	☐ K-Baby - ***Check here and complete the following:***
Medicaid #: _____	Mother's Name:_____
Date of Birth: ___/____/____ Age:_____Sex: _____ (M or F)	Mother's Date of Birth: _____

II. HOME HEALTH AGENCY INFORMATION

Name : _____ MS Medicaid Provider #: _____
Address:_____
_____
_____

III. RECONSIDERATION REQUESTED BY:

Request Date: _____/_____/_____ Time Telephone Request Received: _____
Request Method: ☐ Fax ☐ Mail ☐ Telephone
Requested By: ☐ Agency ☐ Physician ☐ Beneficiary/Representative
Requester Name: _____
Requester Phone #: (____) _____-_____ Ext. _____
Physician Name: _____ Physician MS Medicaid #: _____
(Last) (First)
Physician Phone #: (____) _____-_____ Ext. _____

IV. RECONSIDERATION INFORMATION

Date of denial issue notification: ____/____/_____Service From/Thru Dates: _____
Rationale/medical reason for disagreement: _____
_____
_____
_____
_____

Is additional information being submitted along with this request? ☐ Yes ☐ No

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

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