

HealthSystems of Mississippi Medicaid

Home Health Certification Review – Quality Re-review Request Form

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I. BENEFICIARY INFORMATION	
PATIENT INFORMATION	K-BABY -CHECK BOX AND COMPLETE BELOW:
Patient/Baby Name: _____	<input type="checkbox"/> K-Baby - <i>Check here and complete the following:</i>
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. QUALITY RE-REVIEW REQUESTED BY:	
Request Date: ___/___/___	
Requested By: <input type="checkbox"/> Agency <input type="checkbox"/> Physician	
Requester Name: _____	
Requester Phone #: (____) _____ - _____ Ext. _____	
Physician Name: _____ Physician MS Medicaid #: _____	
(Last) (First)	
Physician Phone #: (____) _____ - _____ Ext. _____	
IV. QUALITY RE-REVIEW INFORMATION	
Date of quality issue notification: ___/___/___ Service From/Thru Dates: _____	
Rationale/medical reason for disagreement: _____	

Is additional information being submitted along with this request? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

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