

**Instructions for Completing the HealthSystems of Mississippi Medicaid Home Health Care
Certification Review –Quality Re-review Request Form**

Section I Beneficiary Information

1. **Patient Name** - Enter the patient's last and first name as it appears on the Mississippi Medicaid ID card. If the beneficiary is a K-baby, list baby's name.
2. **Medicaid #** - Enter the beneficiary's Medicaid number that appears on the Mississippi Medicaid ID card.
3. **Date of Birth** - Enter the month, date, and year of the patient's birth.
4. **Age** - Enter the age of the patient at the time service is to be rendered.
5. **Sex** - Indicate the sex of the patient.
6. **K-Baby** - Indicate if the patient is a K-baby.
7. **Mother's Name** - Enter the full name of the K-baby's mother.
8. **Mother's Date of Birth** - Enter the month, date, and year of the mother's birth.

Section II Home Health Agency Information

1. **Agency Name** - Enter the name of the agency that will provide the care.
2. **Medicaid #** - Enter the agency's Mississippi Medicaid Provider Number.
3. **Address** - Enter the home health agency's complete mailing address or post office box, including city, state, and zip code.

Section III Quality Re-Review Requested By:

1. **Request Date** - Record the date of the request.
2. **Requested By** - Check the box(es) to indicate the party(s) requesting the appeal/re-review.
3. **Requester Name** - Enter the name of the individual who is primary contact at the Home Health Agency for this case. If the patient/beneficiary is the requester, enter the beneficiary/representative name.
4. **Requester Phone #** - Enter the contact person's telephone number, including area code and extension. If the patient/beneficiary is the requester, enter the beneficiary/representative name.
5. **Physician Name** - Enter the first and last name of the physician who ordered the home health care.
6. **Mississippi Medicaid Billing # or Medical License #** - Enter the ordering physician's Mississippi Medicaid billing number or Mississippi medical license number.
7. **Physician Phone #** - Enter the physician's telephone number, including area code and extension.

Section IV Quality Re-review Information

1. **Date of Quality Issue/Notification** - Enter the date of the HHA Notice of Quality Issue.
2. **Rational/medical reason for disagreement** - Enter the rationale/medical reason for disagreement with the review findings.
3. **Is additional information being submitted along with this request** - Check the appropriate box to indicate whether additional information is attached to the form, (i.e., copies of medical records, correspondence, etc.)