HealthSystems of Mississippi MYPAC
Additional Medical Information Form

BENEFICIARY INFORMATION	PROVIDER INFORMATION
Youth's Name: *(Please Print)* _____	MYPAC Medicaid #: ☐☐☐☐☐☐☐☐☐
MS Medicaid #: ☐☐☐☐☐☐☐☐☐	MYPAC Provider Name: *(Please print)* _____
Check if Medicaid # applied for: ☐ **Enter HSM Pseudo #.**	
HSM Pseudo #: ☐☐☐☐☐☐☐☐☐	Requester's Name: *(Please print)* _____
Date of Birth: ☐☐/☐☐/☐☐	Phone #: (☐☐☐) ☐☐☐-☐☐☐☐
Sex: ☐ Age: ☐☐	Ext. ☐☐☐☐☐
Date of Admission: ☐☐/☐☐/☐☐	
Date This information Submitted: ☐☐/☐☐/☐☐	

Information Requested by: *(if applicable)* _____

(HSM Reviewer Name / Number)

ADDITIONAL MEDICAL INFORMATION

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

HEALTHSYSTEMS OF MISSISSIPPI'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.