

Instructions for Completing the HealthSystems of Mississippi MYPAC Additional Medical Information Form

NOTE: The Additional Medical Information Form serves two purposes as noted below.

1. Serves as an **attachment** to the MYPAC Admission Certification Request Form or to the MYPAC Continued Care Certification Request Form when additional space is needed.
2. Serves as a form to submit additional information requested by HSM and required to complete the review process.

NOTE: Please do not resubmit the MYPAC Admission Certification Request Form or MYPAC Continued Care Certification Request Form when additional information is requested by HSM.

Section I Beneficiary Information

1. **Youth's Name** - Enter the youth's last and first name. If the youth has an active MS Medicaid number record the name as it appears on the Mississippi Medicaid ID card.
2. **MS Medicaid #** - If the youth has an active MS Medicaid number, enter the number that appears on the MS Medicaid ID card. If the youth does not have an active number, LEAVE BLANK.
3. **Check if Medicaid applied for** - Check the box if the youth does not have an active Mississippi Medicaid ID.
4. **Enter HSM Pseudo #** - Enter the temporary number assigned by HSM in this space.
5. **Date of Birth** - Enter the month, date, and year of the youth's birth.
6. **Sex** - Indicate the sex of the youth.
7. **Age** - Enter the age of the youth at the time service is to be rendered.
8. **Admit Date** - Enter the actual admission date.
9. **Date This Information Submitted** - Enter the date in which you submit additional information.

Section II Provider Information

1. **MYPAC MS Medicaid Number** - Enter the MYPAC Waiver Medicaid provider number.
2. **MYPAC Provider Name** - Enter the name of the MYPAC Waiver provider.
3. **Requester's Name** - Enter the name of the individual who is primary contact for this case.
4. **Phone #** - Enter the requester's telephone number, including area code and extension, if applicable.

Section III Additional Medical Information

1. **Information Requested by** - Enter the name or number of the HSM reviewer that requested the additional information (if applicable).
2. **Additional Medical Information** - Enter all information requested and any additional supporting documentation to support the medical necessity for certification.