HealthSystems of Mississippi
MYPAC Reconsideration Request Form

YOUTH'S INFORMATION	PROVIDER INFORMATION
Youth's Name: *(Please Print)* ____________	MYPAC MS Medicaid #: ☐☐☐☐☐☐☐☐☐
MS Medicaid #: ☐☐☐☐☐☐☐☐☐	MYPAC Provider Name: *(Please Print)* ____________
Check if Medicaid # applied for: ☐ **Enter HSM Pseudo #:**	
HSM Pseudo #: ☐☐☐☐☐☐☐☐☐	
Date of Birth: ☐☐/☐☐/☐☐	***For HSM Use Only:*** ☐ Telephone Request
Sex: ☐ Age: ☐☐	*Time of Request:* ☐☐:☐☐ ☐ a.m. ☐ p.m.

REQUEST INFORMATION

Request Date: ☐☐/☐☐/☐☐	Requester's Information: *(Please Print)*	Attending Physician Information: *(Please Print)*
Method: ☐ Fax ☐ Mail	Name: *(First, Last)*	Name: (*First, Last)*
Requested By: ☐ MYPAC Provider ☐ Beneficiary/Representative	Telephone Number: (________) ______-__________ Ext.__________	MS Medicaid #:

RECONSIDERATION INFORMATION

Date of denial notification: ☐☐/☐☐/☐☐ Date of Admission: ☐☐/☐☐/☐☐

Rationale/medical reason for disagreement:____

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Is additional information being submitted? ☐ Yes ☐ No

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