

HealthSystems of Mississippi

MYPAC ADMISSION CERTIFICATION REQUEST FORM

| YOUTH'S INFORMATION | PROVIDER INFORMATION |
|--|--|
| Youth's Name: <i>(Please print)</i> _____ MS Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | MYPAC Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Check if no active Medicaid #: <input type="checkbox"/> Enter Soc. Sec. # below: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | MYPAC Provider Name: <i>(Please print)</i> _____ |
| Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> | Request Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> |
| Sex: <input type="checkbox"/> Age: <input type="text"/> <input type="text"/> | Requester's Name: <i>(Please print)</i> _____ |
| Guardian/Representative Name: <i>(Please print)</i> _____ | Phone #: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Guardian/Representative Address: <i>(Please print)</i> _____ _____ | Ext. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

| PHYSICIAN INFORMATION | |
|--|--|
| Medical Director Name: <i>(Please print)</i> _____ | Medical Director MS Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Medical Director Address: (only if no MS Medicaid #) <i>(Please print)</i> _____ _____ | Medical Director Phone #: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

| MEDICAL INFORMATION | |
|--|--|
| Planned Date of Admission: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> | IQ: <input type="text"/> <input type="text"/> <input type="text"/> |
| Diagnosis/Five Parts of Multi-Axial <i>(Please print)</i> | ICD-9-CM Codes |
| I. | |
| II. | |
| III. | |
| IV. | |
| V. | |

| REQUESTED SERVICES | | | | |
|--------------------|-----------------|---|---|--|
| HCPCS Code | Description | Dates of Service | | Total Unit (s) Requested |
| | | From | Thru | |
| H2022 | Wrap around | <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> | Days: <i>(Maximum = 365)</i> |
| T2022 | Case Management | <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> | Months: <i>(Maximum = 12)</i> |
| H0045 | Respite | <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> | Days: <i>(Maximum = 29 at initial cert)</i> |

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Beneficiary Name: _____ MS Medicaid #:

CLINICAL INFORMATION

Psychiatric History. *List a brief history of the youth's psychiatric care.*

Current Behavior. *Please provide a detailed explanation why the beneficiary requires this intensity of services:*

List any previous admissions (to any provider) in the past 3 months. *(Please include shelters, group or foster homes, detention center, training schools or outpatient therapy.)*

List any discharge plans.

Physician Attestation, Signature and Date

A physician who attests to prescribed MYPAC Waiver Services, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the ordering physician identified on this form and I deem the service medically necessary for the patient listed as the beneficiary. I certify that the medical necessity information on this form is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

A copy of an independent evaluation completed by a psychiatrist or psychologist which indicates the need for psychiatric residential treatment and the potential for benefit from psychiatric residential treatment is attached to this form. This evaluation was performed within the last 60 days prior to the proposed admission date.

MYPAC Waiver Medical Director's Signature

Date

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.