

**Instructions for Completing the HealthSystems of Mississippi Medicaid  
Quality Re-review Request Form**

**Section I Beneficiary Information**

1. **Beneficiary Medicaid #** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card.
2. **Beneficiary Name** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card
3. **Date of Birth** - Enter the month, date, and year of the beneficiary's birth. (Use two-digit numbers)
4. **Sex** - Indicate the sex of the patient.
5. **Age** - Enter the age of the beneficiary at the time service is to be rendered.

**Section II Provider Information**

1. **Facility MS Medicaid Number** - Enter the facility's Mississippi Medicaid provider number.
2. **Facility Name** - Enter the name of the facility that will render the treatment.

**Section III Request Information**

1. **Request Date** - Record the date of the request.
2. **Requested By** - Indicate whether the physician or facility made the request.
3. **Requester Name** - Enter the name of the individual requesting the review
4. **Requester Tel #** - Enter the telephone number of the requester including area code.
5. **Physician Name** - Enter the name of the physician rendering the service.
6. **Physician MS Medicaid #** - Enter the physician's Mississippi Medicaid provider number.

**Section IV Quality Re-review Information**

1. **Date of Quality Issue Notification** - Enter the date quality letter was issued.
2. **Date of Admission** - Enter the date the patient was admitted to the facility.
3. **Rationale for Request** - Enter the medical basis/rationale for disagreement.
4. **Additional information submitted** - Indicate whether additional information was submitted with the request.