

**Instructions for Completing the HealthSystems of Mississippi
Outpatient Physical/Occupational/Speech Therapy
Reconsideration Request Form**

Section I Beneficiary Information

1. **Patient Name** - Enter the patient's last and first name as it appears on the Mississippi Medicaid ID card. If the beneficiary is a K-baby, list baby's name.
2. **Medicaid #** - Enter the beneficiary's Medicaid number that appears on the Mississippi Medicaid ID card.
3. **Date of Birth** - Enter the month, date, and year of the patient's birth.
4. **Age** - Enter the age of the patient at the time service is to be rendered.
5. **Sex** - Indicate the sex of the patient.
6. **K-Baby** - Indicate if the patient is a K-baby.
7. **Mother's Name** - Enter the full name of the K-baby's mother.
8. **Mother's Date of Birth** - Enter the month, date, and year of the mother's birth.

Section II Provider Information

1. **Provider Name** - Enter the name of the provider that will provide the care.
2. **Medicaid #** - Enter the provider's Mississippi Medicaid Provider Number.
3. **Address** - Enter the provider's complete mailing address or post office box, including city, state, and zip code.

Section III Reconsideration Requested By:

1. **Request Date** - Record the date of the request.
2. **Time Telephone Request Received** - For HSM use to enter time telephone request received.
3. **Request Method** - Indicate whether request submitted by fax, mail or telephone.
4. **Requested By** - Indicate whether the therapist, physician, nurse practitioner, physician assistant, or beneficiary/representative made the request.
5. **Requester Name** - Enter the name of the individual who is primary contact for this case. If the patient/beneficiary is the requester, enter the beneficiary/representative name.
6. **Requester Phone #** - Enter the contact person's telephone number, including area code and extension. If the patient/beneficiary is the requester, enter the beneficiary/representative name.
8. **Physician/Nurse Practitioner/Physician Assistant Name** - Enter the first and last name of the physician, nurse practitioner or physician assistant who ordered the therapy.
9. **Mississippi Medicaid Billing # or Medical License #** - Enter the ordering MD/NP/PA Mississippi Medicaid billing number or Mississippi medical license number.
10. **Physician/Nurse Practitioner/Physician Assistant Phone #** - Enter the MD/NP/PA telephone number, including area code and extension.

Section IV Reconsideration Information

1. **Date of Denial Issue Notification** - Enter the date of the provider's Notice of Review Outcome.
2. **Service From/Thru Dates:** Enter the dates of service certified.
3. **Rational/medical reason for disagreement** - Enter the rationale/medical reason for disagreement with the review findings.
4. **Is additional information being submitted along with this request** - Check the appropriate box to indicate whether additional information is attached to the form, (i.e., copies of medical records, correspondence, etc.)