

HealthSystems of Mississippi

Outpatient Physical/Occupational/Speech Therapy

Reconsideration Request Form (Page 1 of 1)

I. BENEFICIARY INFORMATION

PATIENT INFORMATION	K-BABY -CHECK BOX AND COMPLETE BELOW:
Patient/Baby Name: _____ 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"/> Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Age: <input type="text"/> <input type="text"/> <input type="text"/> Sex: <input type="text"/> (M or F)	<input type="checkbox"/> K-Baby - <i>Check here and complete the following:</i> Mother's Name: _____ Mother's Date of Birth: _____ <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

II. PROVIDER INFORMATION

Name : _____	Medicaid Provider #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Address: _____ _____	

III. RECONSIDERATION REQUESTED BY:

Request Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Time Telephone Request Received: _____
Request Method: <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Telephone	
Requested By: <input type="checkbox"/> Therapist <input type="checkbox"/> Physician/NP/PA <input type="checkbox"/> Beneficiary/Representative	
Requester Name: _____	
Requester Phone #: (____) _____ - _____ Ext. _____	
Physician/NP/PA Name: _____ Medicaid Provider #: _____	
Physician/NP/PA Phone #: (____) _____ - _____ Ext. _____	

IV. RECONSIDERATION INFORMATION

Date of denial issue notification: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Service From Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Thru Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Rationale/medical reason for disagreement: _____ _____ _____ _____
Is additional information being submitted along with this request? <input type="checkbox"/> Yes <input type="checkbox"/> No

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