Instructions for Completing the HealthSystems of Mississippi
Outpatient Physical/Occupational/Speech Therapy
Quality Re-review 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 outpatient therapy 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 Quality Re-Review Requested By:

1. ***Request Date*** - Record the date of the request.
2. ***Requested By*** - Check the box(es) to indicate the party(s) requesting the re-review.
3. ***Requester Name*** - Enter the name of the individual who is primary contact for this case.
4. ***Requester Phone #*** - Enter the contact person's telephone number, including area code and extension.
5. ***Physician/Nurse Practitioner/Physician Assistant Name*** - Enter the first and last name of the Physician/Nurse Practitioner/Physician Assistant who ordered the therapy.
6. ***Mississippi Medicaid Billing # or Medical License #*** - Enter the ordering MD/NP/PA Mississippi Medicaid billing number or Mississippi medical license number.
7. *Physician/Nurse Practitioner/Physician Assistant* ***Phone #*** - Enter the ordering MD/NP/PA's telephone number, including area code and extension.

Section IV Quality Re-review Information

1. ***Date of Quality IssueNotification*** **-** Enter the date of the provider's Notice of Quality Issue.
2. ***Service From/Thru Dates:*** Enter the dates of service for the patient.
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.)