

HealthSystems of Mississippi

Outpatient Physical/Occupational/Speech Therapy

Quality Re-review 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"/> <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="checkbox"/> (M or F) <input type="checkbox"/> (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. QUALITY RE-REVIEW 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"/> Requested By: <input type="checkbox"/> Therapist <input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician Assistant Requester Name: _____ Requester Phone #: (____) _____ - _____ Ext. _____ Physician/NP/PA Name: _____ Medicaid Provider #: _____ Physician/NP/PA Phone #: (____) _____ - _____ Ext. _____	
IV. REREVIEW INFORMATION	
Date of quality 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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