

**Instructions For Completing the HealthSystems of Mississippi  
Outpatient Physical/Occupational/Speech Therapy  
Precertification 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 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.
9. **Therapy in other setting** – Indicate either yes or no if the patient is receiving therapy in any other setting.
10. **Place of Service Code** – If the patient is receiving therapy in another setting, indicate the place of service code.
11. **Last Physician, Nurse Practitioner, or Physician Assistant's Visit** – Enter the date of the last visit with the practitioner's.
12. **Next Scheduled Physician, Nurse Practitioner, or Physician Assistant's Appointment** – Enter the date of the next scheduled practitioner's appointment.

**Section II                    Provider Information**

1. **Request Date** – Record the date of the request.
2. **Medicaid #** - Enter the provider's Mississippi Medicaid Provider Number.
3. **Provider Name** - Enter the name of the provider that will provide the care.
4. **Contact/Requester** - Enter the name of the individual who is primary contact for this case.
5. **Telephone #** - Enter the contact person's telephone number, including area code and extension.
6. **Fax #** - Enter the provider's contact fax number, including area code.
7. **Intended Place of Service Code** – Indicate the intended place of service code.
8. **Ordering Physician, Nurse Practitioner, or Physician Assistant** – Indicate the name of the ordering MD/NP/PA.
9. **Telephone #** - Indicate the telephone number of the ordering MD/NP/PA.
10. **Services to be Provided By** – Indicate the type of provider that will provide therapy services.

**Section III                    Request Type**

1. **Precertification** - If the request is for precertification, insert the following:
  - A. **Date of Evaluation Visit** - Enter the date of initial evaluation visit provided to patient.
  - B. **Date of Next Planned Visit** - Enter date of the next scheduled visit to provide therapy service to patient.
  - C. **No Additional Visits Planned** – Indicate if patient does not qualify for or need additional therapy visits.

**NOTE: Attach a Copy of the Physician, Nurse Practitioner or Physician Assistant's Order (verbal or written), Initial Evaluation Visit notes and Plan Of Care.**

2. **Urgent or Same Day Non-Urgent** - Insert the following:
  - A. **Date of evaluation Visit** - Enter the date of initial evaluation visit provided to the patient.
  - B. **Date of Next Planned Visit** - Enter date of the next scheduled therapy visit.
  - C. **No Additional Visits Planned** – Indicate if patient does not qualify for or need additional therapy visits.
  - D. **Reason for Urgent Services** - Indicate reason(s) the urgent services were required.

**NOTE: This area should be completed for urgent services rendered at any point in the patient’s care. Attach a copy of the order, initial evaluation assessment visit notes and plan of care.**

3. **Concurrent** - If the request is for concurrent review (certification for continuing services), complete the following:
  - A. **Existing Certification #** - Enter existing certification number.
  - B. **Date of Last Service Authorized** - Enter the date of last service authorized.
  - C. **Date of Next Planned Visit** - Enter the date of the next scheduled therapy visit.

**NOTE: Current Physician, Nurse Practitioner, or Physician Assistant’s orders, current plan of care, notes from therapist’s last visit, and documentation of patient’s progress toward achieving goals.**

4. **Retrospective** - Check box for retrospective review and complete the following, if applicable:
  - A. **TCN** - Transaction Control Number

**NOTE: A copy of the patient’s complete medical record must be attached to this request form.**

## **Section IV. Diagnoses and ICD-9-CM Codes**

1. **Medical Diagnoses/ICD-9-CM Codes** - Enter the patient’s primary and secondary diagnoses for this admission (if applicable) and enter the ICD-9-CM codes that correspond to the diagnoses.
2. **Therapy Diagnoses/ICD9-CM Codes** – Enter the patient’s therapy diagnoses for this admission (if applicable) and enter the ICD-9-CM codes that correspond to the diagnoses.

## **Section V. Requested Therapy**

1. **Therapy Type** – Indicate if therapy type is physical (PT), occupational (OT) or speech therapy (ST).
2. **Narrative Description of Procedure** – Indicate a narrative description of the CPT code procedure.
3. **CPT Code** – Use a valid CPT code.
4. **Frequency** – Indicate the number of times services are to be rendered per duration, such as 3 times per week for 4 weeks.
5. **Units** –
  - a. Record the number of units requested per visit for each CPT code.
  - b. Record the total number of units requested for each CPT code.
6. **Dates of Service** – Indicate date service will start and the date the service will end.
7. **Signature of Provider** – Indicates that the services listed in Section V of this form are those exact services ordered and certified as medically necessary by the ordering MD/NP/PA specified in Section II of this form for the beneficiary specified in Section I of this form.