

LIST OTHER PROVIDERS HERE THAT NEED A COPY OF THIS FORM.

Plan of Care Type:

- M - Mental Health
- P - Psychiatric Services
- S - Expanded Cool Kid Services (EPSDT)
- V - Expanded Visits

MISSISSIPPI MEDICAL ASSISTANCE PROGRAM

AUTHORIZATION NUMBER

PLAN OF CARE

AUTHORIZATION REQUEST

APPROVAL OF THESE SERVICES DOES NOT GUARANTEE MEDICAID ELIGIBILITY OF THE PATIENT. REIMBURSEMENT FOR THESE SERVICES WILL BE MADE ACCORDING TO THE MEDICAID FEE SCHEDULES AND POLICY PROVIDED THE PATIENT IS ELIGIBLE ON THE DATE OF SERVICE. THIS FORM IS LIMITED TO CHILDREN FROM BIRTH TO AGE 21.

FOR PROVIDER USE

PROVIDER INFORMATION

1. NAME OF PHYSICIAN: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NO: _____

PROVIDER NO: _____

MEDICAL DATA

2. A. PRIMARY DIAGNOSIS: _____

B. SECONDARY DIAGNOSIS: _____

C. EXPECTED LENGTH OF TREATMENT: _____

D. SIGNIFICANT PROBLEMS/JUSTIFICATION: _____

E. MS COOL KIDS SCREENING: YES NO

ATTACH SUPPORTING DATA TO JUSTIFY MEDICAL NECESSITY.

PATIENT INFORMATION

3. NAME OF PATIENT: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

MEDICAID NO: _____ DOB: _____

SEX M F

FAMILY OR RESPONSIBLE PARTY (NAME, ADDRESS, PHONE NO.): _____

PATIENT IS: HOSPITAL HOME OTHER _____

THIRD PARTY COVERAGE: YES NO HOME HEALTH YES NO

FOR MEDICAID USE

5. AUTHORIZATION IS FOR SPECIFIC PROVIDER YES NO

REVIEWERS COMMENTS: _____

AUTHORIZING AGENT _____

TITLE _____ DATE _____

SERVICES REQUESTED

	A. PROCEDURE DESCRIPTION	B. PROCEDURE/NDC CODE OR ABBREVIATION
1		
2		
3		
4		
5		
6		
7		
8		
9		

SERVICES APPROVED

A. YES	B. NO	C. APPROVED DATES FROM THRU	D. UNIT/QT.	E. AMOUNT	F. PER UNIT AMOUNT

7. _____

SIGNATURE OF PHYSICIAN / NURSE PRACTITIONER _____ TITLE _____ DATE _____

I CERTIFY THAT I HAVE SEEN THIS CHILD AND THAT ALL THE SERVICES REQUESTED ARE MEDICALLY NECESSARY

FORWARD TO: DIVISION OF MEDICAID
 SUITE 801, ROBERT E. LEE BLDG.
 239 N. LAMAR ST
 JACKSON, MS 39201-1311

DOM'S COPY