HEALTHY MISSISSIPPI

Healthy Mississippi, Inc.
10 Canebrake Boulevard,
Suite 110
Flowood, MS 39232
1-833-201-6413 TTY: 711
1-662-350-0412 (Fax)

AUTHORIZATION REVIEW FORM FOR HEALTH CARE SERVICES

SECTION I - SUBMISSION

Issuer Name: _____

Request Date: _____

Phone: _____

Fax: _____

SECTION II - GENERAL INFORMATION

Review Type: [ ] Non-Urgent [ ] Urgent

Clinical Reason for Urgency: _____

Request Type: [ ] Initial Request. [ ] Extension Previous Authorization #: _____

Place of Service:

[ ] Inpatient [ ] Observation [ ] Outpatient

[ ] Provider Office [ ] Home [ ] Day Surgery [ ] Other: _____

SECTION III - PATIENT INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____

Gender: [ ] Male. [ ] Female [ ] Other [ ] Unknown

Subscriber Name (if different): _____

Member or Medicaid ID #: _____

Plan Name: _____

SECTION IV - PROVIDER INFORMATION

Requesting Provider or Facility: Name: _____

Tax ID: _____

Phone: _____ Fax: _____

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Contact Name: _____

Address: _____

NPI: _____

Service Provider/Facility: Name: _____

Tax ID: _____

Phone: _____Fax: _____

Address: _____

NPI #: _____

Requesting Provider's Signature and Date: _____

SECTION V - SERVICES REQUESTED

[ ] Physical Therapy [ ] Occupational Therapy [ ] Speech Therapy [ ] Cardiac Rehab [ ] Mental Health/Substance Abuse [ ] Home Health (Attach MD Signed Order and Nursing Assessment) [ ] Equipment/Supplies

Planned Service/Procedure	Code (CPT, HCPCS, Revenue)	Units	Start Date	End Date	Diagnosis Description	ICD-10 Code

(Attach additional pages if needed)

Note: Attach clinical documentation to this form upon submission. Failure to complete applicable fields may delay processing.

Member Services: 1-833-201-6413 TTY:711