HEALTHSYSTEMS OF MISSISSIPPI
PLAN OF CARE FORM

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Beneficiary Name: _____

Medicaid #: _____

Date of Birth: ___/___/___ Age:____ Sex: ____ (M or F)

☐ K-Baby - *Check here and complete the following:*

Mother's Name: _____

Mother's Date of Birth: _____

DME Provider: _____

Address:

_____

_____

Medicaid Provider #: _____

Requester/Contact: _____

Telephone #: _____ Ext._____

Fax #: _____

Ordering MD/NP/PA Name (First and Last):

_____

Medicaid ID# or MS License #: _____

Telephone #: (____) _____-_____ Ext. _____

FOR HSM USE ONLY:

Retrospective Review? ☐ Yes ☐ No If Yes, enter date Medicaid eligibility became effective: _____

SECTION B REQUESTED EQUIPMENT, ORTHOTIC, PROSTHETIC AND DIAPERS/UNDERPADS

	Equipment/Supply Description	Equipment/ Supply Code	Modifier	*Unspecified Code Charge or Repair Charge	Deliver Date (Enter only if item has been delivered)	Dates of Need From	Thru	QTY (#)
1								
2								
3								
4								
5								
6								

** The DME provider must indicate the name of the product, the product number, and the name of the manufacturer or distributor and must provide the required documentation for manual pricing. Please refer to Division of Medicaid's DME provider policy manual (section 10.02) for manual pricing documentation requirements.*

SECTION C PROVIDER ATTESTATION, SIGNATURE AND DATE

I certify that those items listed in Section B of this form are those exact items ordered and certified as medically necessary by the ordering physician/nurse practitioner/physician assistant specified in Section A of this form, and that these exact items listed in Section B of this form will be delivered to the beneficiary specified in Section A of this form. A DME provider who knowingly or willingly makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may be automatically disqualify the provider as a provider of Medicaid services.

_____ _____

Signature of DME Provider Date

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

HealthSystems of Mississippi's certification determination does not guarantee Medicaid payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.