OFFICE OF THE GOVERNOR
Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF MEDICAID

Click here to enter a date.

CERTIFIED MAIL

Provider Name
Attention: Contact Person
Address
City, State Zip Code

Re: Recovery Audit Request for Medical Records

Dear Provider:

The Mississippi Division of Medicaid, Office of Program Integrity, is reviewing a potential overpayment of your Medicaid paid claim(s). In accordance with Title XIX of the Social Security Act, the implementing federal regulations 42 CFR Part 455, and the Mississippi Code of 1972, Title 43, Chapter 13, as amended, as a Medicaid participating provider, you must provide documentation and medical records upon request to support claims for Medicaid services. Enclosed with this letter is a Records Request List for services provided to Click here to enter text. ( ) Medicaid beneficiary(s). This is an official request for copies of the beneficiaries' complete medical records: including physician office visit notes, operative notes, photographs, nurses' notes, and any other documentation that will support the services and the medical necessity for the services billed for the dates of service requested.

Please submit along with a copy of this letter, copies of the requested records and documentation within thirty (30) calendar days from receipt of this letter to the following address:

Mississippi Division of Medicaid
Attn: Office of Program Integrity
Walter Sillers Building; 550 High Street; Suite 1000
Jackson, MS 39201

Upon receipt, submitted documentation will be reviewed to determine if the services billed are reasonable and necessary and meet all other requirements for Medicaid coverage. Following the review, you will be informed in writing of our findings.

Enclosed please find a copy of the Office of Program Integrity's "Records Request Authorization Packet" which includes HIPAA guidelines and Mississippi State Law regarding medical records and your requirements as a participating Mississippi Medicaid provider to provide the requested

information. If you have any questions, you may contact at Click here to enter text.. Thank you for your assistance in this matter.

Sincerely,

MISSISSIPPI DIVISION OF MEDICAID

Click here to enter text.
Click here to enter text.
Office of Program Integrity

Enclosures

cc:
Choose an item.

MISSISSIPPI DIVISION OF MEDICAID

MEDICAID PROVIDER RECORDS REQUEST LIST

Click here to enter a date.

Provider Name:
Provider ID:
Medicaid Representative:
Medicaid Representative:

	Beneficiary Name	Medicaid ID#	Date of Birth	SS # (last 4 digits)	Date of Service	Comments
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MISSISSIPPI DIVISION OF MEDICAID

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