

*** = Required Information**

Requestor's

Contact Name:

Requestor's

Contact Number:

PATIENT INFORMATION

*Name: _____ *Date of Birth: _____

*Member ID Number: _____ *Member Phone Number: _____

*Inpatient Notification: ☐ Elective Pre-certified ☐ Emergency Admission ☐ Transfer from Outside Hospital

*☐ Direct Admit ☐ OB Services ☐ Other Services (please specify) _____

***INPATIENT BED TYPE REQUESTED**
Acute Care

- ☐ ICU
☐ Neuro/Spinal
☐ Pediatric ICU
☐ Trauma
☐ Transplant

Acute Care

- ☐ Intermediate CCU
☐ Cardiovascular Unit
☐ Oncology Unit
☐ Orthopedic Unit
☐ Telemetry
☐ Detox
☐ Medical
☐ Surgical

Other

- ☐ Hospice
☐ Intensive Rehab
☐ Psych/Mental Health
☐ Skilled Nursing
☐ Subacute Rehab
☐ Substance Abuse/Chemical Dependency
☐ Swing Bed

OB/Newborn

- ☐ OB Non-Delivered
☐ OB Surrogacy C-Section
☐ OB Surrogacy Vaginal
☐ OB Vaginal Delivery
☐ OB C-Section
☐ Nursery Readmit
☐ Nursery Boarder Baby
☐ NICU II
☐ NICU III
☐ NICU IV

MEMBER ADMISSION INFORMATION
***ICD-10**

Admitting Diagnosis: _____

Description of Diagnosis: _____

* Date of Admit: _____

Date of Discharge is applicable: _____

FACILITY INFORMATION
FACILITY:
☐

*Name: _____ *NPI: _____ *TIN: _____

*UR Fax: _____ *UR Phone: _____

*Address: _____

Case Manager:
☐

*Name: _____

*Fax: _____ *Phone: _____

Request for extension to authorization: _____

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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