

# Admission/Concurrent Review Fax Form

Admission and discharge notification required. If we don't receive notification and medical records, claims may pend or deny.

**Maternity Admission Exception:** Maternity admission notifications are required only if the patient's stay is over 48 hours for vaginal birth or 96 hours for a C-section, from the date of delivery.

**Complete and fax to: 888-742-1487 (Form MUST be on the first 2 pages of submission and cannot be handwritten)**

Complete all required* fields.	
<b>*MEMBER/PATIENT</b> _____ <b>*Date of Birth</b> _____ <b>*Member ID</b> _____ <b>*Suffix</b> _____ <b>Group #</b> _____	
<b>Maternity only (NICU):</b> Birth Mother's Name: _____ Baby Gender: _____ Twins: <input type="checkbox"/>	
<b>Facility Contact:</b> <b>*Contact name:</b> _____ <b>*Phone:</b> _____ <b>*Fax:</b> _____ <b>Utilization Review Information:</b> <b>*Phone:</b> _____ <b>*Fax:</b> _____	<b>Facility:</b> <b>*Facility name:</b> _____ <b>*Address:</b> _____ <b>*City:</b> _____ <b>State:</b> _____ <b>ZIP:</b> _____ <b>*TIN # (required):</b> _____ <b>NPI # (required):</b> _____  <b>*Type of Admit:</b> (check only one box)  <b>Acute Inpatient:</b> (Fax medical records to <b>888-742-1487</b> .) <input type="checkbox"/> Detox <input type="checkbox"/> Psychiatric admit <input type="checkbox"/> Planned <input type="checkbox"/> Emergency <input type="checkbox"/> Neonatal intensive care unit (NICU) <input type="checkbox"/> Direct admit from provider's office  <b>Lower Levels of Care:</b> (Fax medical records to <b>888-742-1487</b> .) <b>Prior authorization required for all lower levels of care listed below</b> <input type="checkbox"/> Inpatient Rehab (IPR) <input type="checkbox"/> Neuro Rehab <input type="checkbox"/> Skilled Nursing (SNF) <input type="checkbox"/> Long-term Acute Care (LTAC) <input type="checkbox"/> Residential Treatment Center (RTC) – Detox (Level 3.7) <input type="checkbox"/> Residential Treatment Center (RTC) <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use (Level 3.3-3.5) <input type="checkbox"/> Eating Disorder (Choose primary diagnosis above)  ***Observation – No Notification Needed – Do not Submit Form
<b>Admission:</b> <b>*Admit date:</b> _____ Discharge date: _____ Pending <input type="checkbox"/> <b>*ICD diagnosis code:</b> _____ <b>*Procedure code (CPT):</b> _____ <b>Required for Surgical Admissions</b>	<b>Admitting Physician:</b> <b>*Physician name:</b> _____ <b>*Phone:</b> _____ <b>*Fax:</b> _____  Hospitalist (Address same as Facility) <input type="checkbox"/> Not a Hospitalist (Address required below) <input type="checkbox"/>  Address: _____ City: _____ State: _____ ZIP: _____ TIN (required) #: _____ NPI# (required): _____
<input type="checkbox"/> <b>URGENT REQUEST</b> Urgent requests must be signed and include supporting documentation from the provider's office, noting that standard timeframes for making a non-urgent determination could: <ul style="list-style-type: none"><li>Seriously jeopardize the life/health of the patient or the ability to regain maximum function, <b>or</b></li><li>Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, <b>or</b></li><li>In the opinion of a provider with knowledge of the member's medical or behavioral condition, subject the patient to adverse health consequences without the requested care or treatment.</li></ul> <b>I attest that this request meets the urgent definition described above: MD signature:</b> _____	

This is not a pre-authorization of benefits nor a guarantee of payment. This admission notification is based on diagnosis and medical information submitted and is subject to all contract terms, including, but not limited to, member benefits, benefit maximums and subscription charge payment covering dates of service. Unless specifically requested elsewhere in this document, please do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.

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