

Inpatient Admission/Concurrent Review Request

FEP only – Washington (except Clark County)



Admission precertification and concurrent review is required for all Blue Cross and Blue Shield Federal Employee Program (FEP) members.

Complete and fax this form with medical records to FEP fax 866-948-8823.

Prior authorization required for all admissions

Maternity admission exception: Precertification is 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.

If authorization for a stay is not obtained but inpatient level of care is determined to be medically necessary, payment for the stay will be reduced by \$500.

Discharge notification is also required.

Complete all required* fields.		
*Member ID:	*Patient name:	*Date of Birth:
Facility Contact: *Contact name: *Phone: *Fax: Utilization Review Information: *Phone: *Fax:	Facility: *Facility name: *Address: *City: State: ZIP: *TIN # (required): *NPI # (required):	*Type of Admit: (check only one box) Acute Inpatient: (Fax medical records to FEP fax 866-948-8823) <input type="checkbox"/> Detox <input type="checkbox"/> Planned <input type="checkbox"/> Emergency <input type="checkbox"/> Neonatal intensive care unit (NICU) <input type="checkbox"/> Psychiatric admit <input type="checkbox"/> Direct admit from provider's office Lower Levels of Care: (Fax medical records to FEP fax 866-948-8823) <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)
Admission: *Admit date: *Discharge date: *ICD diagnosis code: *Procedure code: Required for Surgical Admissions	Admitting Physician: *Physician name: *Phone: *Fax: 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"/> URGENT REQUEST 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"> • Seriously jeopardize the life/health of the patient or the ability to regain maximum function, or • Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or • 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. I attest that this request meets the urgent definition described above: MD signature: _____		

This precertification 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.

Confidentiality Notice: The information contained in this facsimile message is privileged or confidential and intended only for the individual or entity named above. If the reader is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by calling 877-342-5258.