## 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.		
*MEMBER/PATIENT	*Date of Birth	
*Member ID*	Suffix Group #	
Maternity only (NICU): Birth Mother's Name:	Baby Gender:	Twins:
Facility Contact:	Facility:	
*Contact name:	*Facility name:	
*Phone:	*Address:	
*Fax:	*City:	State: ZIP:
Utilization Review Information:	*TIN # (required):	NPI # (required):
*Phone: *Fax:	*Type of Admit: (check only one box)	
Admission:		
*Admit date:	Acute Inpatient: (Fax medical records to 888-742-1487.)	
Discharge date: Pending	Detox	Psychiatric admit
*ICD diagnosis code:	Planned	Emergency
*Procedure code (CPT):	Neonatal intensive care unit (NICU)	
Required for Surgical Admissions	Direct admit from provide	r's office
Admitting Physician:		
*Physician name:		edical records to <b>888-742-1487.</b> )
*Physician name.  *Phone:	Prior authorization required f	or all lower levels of care listed below
*Fax:	☐ Inpatient Rehab (IPR)	☐ Neuro Rehab
<u>_</u>	Skilled Nursing (SNF)	Long-term Acute Care (LTAC)
Hospitalist(Address same as Facility)	Residential Treatment Center (RTC) – Detox (Level 3.7)	
Not a Hospitalist (Address required below)□	Residential Treatment Cer	nter (RTC)
Address:		nce Use (Level 3.3-3.5) 🔲 Eating Disorder
City: State: ZIP:	(Choose primary diagno	osis above)
TIN (required) #: NPI# (required):		
· · · · ·	***Observation - No Notificat	tion Needed – Do not Submit Form
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> <li>Seriously jeopardize the life/health of the patient or the ability to regain maximum function, or</li> </ul>		
<ul> <li>Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or</li> </ul>		
• 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 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.

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.