



Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Acute Hospital Admissions Continued Stay Recertification Review

Date: _____ Reference #: _____ (provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call Healthlink at 1-877-284-0102.

Hospital Information

Hospital Name: _____
 Address: _____
 Phone: _____
 Fax: _____

Patient Information

Patient Name: _____
 ID Number: _____
 Patient DOB: _____
 Address: _____
 Phone: _____

Physician Information

Ordering Physician Name: _____
 Address: _____
 Phone: _____
 Fax: _____
 TIN: _____

Daily Clinical Review

All treatment information should be submitted on the Acute Hospital Elective/Emergency Admissions Form

Date of Review: _____
 Floor Type: _____
 Diet: _____
 Vital Signs (if abnormal): _____
 Activity Status: _____
 Pertinent Lab Findings (if abnormal): _____
 Pertinent Medications (IV meds or drips): _____

 Inpatient Interventions: (new diagnosis, tests ordered, surgery planned) _____

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

Discharge Information

If known, please supply the following:

Discharge Planner Name: _____

Phone: _____

Anticipated Discharge Needs: Rehab SNF HHC* Home Infusion*

**Preferred Providers available* DME* Outpatient PT Outpatient OT HOSPICE

Anticipated Discharge Date: _____

Additional Comments

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____