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

Inpatient Acute Hospital Elective/Emergency Admissions Precertification 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.

Physician Information

Admitting Physician Name: ____

Group Practice Name: ____

Address: ____

Phone: _____________________________

Fax: _____________________________

TIN: _____________________________

Patient Information

Patient Name: ____

ID Number: _________________________

Patient DOB: ________________________

Address: ____

Phone: _____________________________

Hospital/Facility Information

Hospital/Facility Name: ____

Address: ____

Phone: _____________________________

Fax: _____________________________

Treatment Information

Primary Diagnosis: ____________________

Diagnosis (ICD-9) Code: _______________

Primary Procedure: ____________________

Procedure (ICD-9) Code: _______________

Procedure Date: ______________________

Admission Date: ______________________

Anticipated Length of Stay: _____________

Bed Type: ☐ Medical ☐ Surgical ☐ ICU/CCU ☐ Other (specify) ____________________

Pertinent Medical History: (submit history, physical and/or hospital discharge summary with this form)_____________

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Please provide daily clinical review on the Inpatient Acute Hospital Admissions Continued Stay Recertification Form

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 Date: ____________________

Anticipated Discharge Needs: ☐ Rehab ☐ SNF ☐ HHC* ☐ Home Infusion*

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

Additional Comments

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Provider Contact Information

Contact Person: ____

Title: ________________________________

Phone: ______________________________

Fax: ________________________________

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