



Utilization Management
Phone No.: 1-877-284-0102 Fax No.: 1-800-510-2162

Inpatient Medical Pre-Review Program

Date: _____ Notification # _____ (provided after initial review)
A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification 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.

Attending Physician Information

Group Practice Name _____
Address _____
Phone No. _____ Fax No. (Required) _____
TIN _____

Patient Information

Patient's Name: _____
ID Number _____ Patient's DOB: _____
Address _____
Height: _____ Weight: _____ Daytime Phone No. _____

Facility or Agency Information

Facility/Agency's Name _____
Address _____
Phone No. _____ Fax No. _____

Treatment Information

Primary Diagnosis: _____ DX (ICD-9): _____, _____
Primary Procedure: _____ RX (ICD-9): _____, _____
Admission Date: _____ Procedure Date: _____
Bed Type: Medical Surgical ICU/CCU Other

Past Medical History/Co-morbidities: _____

Admission Date: _____ Anticipated length of stay: _____

Diagnosis: _____

Pertinent History: _____

Co Morbidities: _____

Daily clinical review is required (unless notified otherwise)

Hospital day/ Date: _____ Floor Type: _____

Current Status: _____

Diet: _____ VS (if abnormal): _____ Activity Status: _____
Lab Findings _____

Pertinent Medications (IV meds or drips): _____

Inpatient interventions: _____

Discharge plans: _____

Daily clinical review is required (unless notified otherwise)

Hospital day/ Date: _____ Floor Type: _____

Current Status: _____

Diet: _____ VS (if abnormal): _____ Activity Status: _____

Lab Findings _____

Pertinent Medications (IV meds or drips): _____

Inpatient interventions: _____

Discharge plans: _____

Additional Comments: _____

Family/Social Support: _____

Discharge Information

Discharge Planner's Name: _____ Telephone No: _____

Anticipated Discharge Needs: Rehab SNF HHC* HI* DME*
 Outpatient PT Outpatient OT HOSPICE

*Preferred Providers available

Discharge Date: _____ Discharge Plan/Needs: _____

Contact Information

Contact Person _____

Phone No. _____ Fax No. _____

Staff Signature/Title: _____ Date: _____

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.