



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

**Request for Continued Stay/Recertification**

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.*

**Hospital Information**

Hospital Name: \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone No. \_\_\_\_\_ Fax: (Required) \_\_\_\_\_

**Patient's Information**

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

**Physician's Information**

Ordering Physician's Name: \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 TIN: \_\_\_\_\_

**Treatment Information**

Admission Date: \_\_\_\_\_ Anticipated length of stay: \_\_\_\_\_  
 Plan of Treatment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current Signs/Symptoms: \_\_\_\_\_  
 \_\_\_\_\_

Lab Findings \_\_\_\_\_  
 \_\_\_\_\_

APPLICABLE LAB TESTS	RESULTS

APPLICABLE MEDICATION(S)	DOSAGE	FREQUENCY	DATE STARTED	DATE STOPPED

**Additional Comments:**

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**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.