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) _____

_____

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: _____