

INPATIENT Notification Form

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INPATIENT NOTIFICATION (ONLY)

Member Name (Last, First)		Member ID#		DOB	Date of Notification
INPT Admit Source		<input type="checkbox"/> Emergency Room		<input type="checkbox"/> Elective Procedure – Prior Auth #	
		<input type="checkbox"/> Alcohol & Drug Treatment Center (ATC)		<input type="checkbox"/> Direct Admit – Admitting Physician	
Admit Type		<input type="checkbox"/> Inpatient			
		<input type="checkbox"/> Observation (*Please note – Observation does not require prior authorization)			
Name of Facility			ED Arrival (Date/Time)		
Facility Address		NPI #		INPT Admit (Date/Time)	
Contact Person		Direct Phone #		Fax #	
Admitting Diagnosis 1 (ICD-10 code)		Admitting Diagnosis 2 (ICD-10 code)		Admitting Diagnosis 3 (ICD-10 code)	
Name of Procedure		CPT code1	CPT code2	CPT code3	CPT code4
* Providers are required to send medical documentation supporting requested service within 1 business day following INPT admit.					
* Providers are required to send updated clinical information <u>24 hours</u> prior to end of days authorized for concurrent review.					

Please fax REQUEST FORM, FACESHEET, and CLINICALS to 1-801-758-3370.

- ❖ Failure to provide requested documentation may result in delayed payment of claims and/or denial of requested services/authorizations.
- ❖ Medical/Clinical information is evaluated using evidence-based criteria along with local delivery systems and other circumstances to determine appropriateness of requested healthcare services.