

# INPATIENT Notification Form

FAX: (801) 587-4855

www.HealthChoiceUtah.com



INPATIENT NOTIFICATION (ONLY)					
Member Name (Last, First)		Member ID#		DOB	Date of Notification
INPT Admit Source		<input type="checkbox"/> Emergency Room <input type="checkbox"/> Alcohol & Drug Treatment Center (ATC)			<input type="checkbox"/> Elective Procedure – Prior Auth # <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	
<p><b>* Providers are required to send medical documentation supporting requested service within <u>1 business day</u> following INPT admit.</b></p> <p><b>* Providers are required to send updated clinical information <u>24 hours</u> prior to end of days authorized for concurrent review.</b></p>					
<p><b>Please fax REQUEST FORM, FACESHEET, and CLINICALS to 1-801-758-3370.</b></p>					

- ❖ 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.