

Date _____

INPATIENT UTILIZATION REVIEW FORM

For assistance, please contact us at: (800) 444-5769 Fax (952)896-1261

Patient _____ DOB _____ Gender _____

ID# _____ Policy Holder _____

Patient Address _____
(Street) (City) (State) (Zip)

Patient Phone # _____

Physician _____ Phone # _____

Facility _____ TIN _____

Diagnosis Code ICD9: _____ ICD9: _____ ICD9: _____

Procedure Code (if applicable) CPT/HCPC: _____ CPT/ HCPC: _____

Admitting Date _____ # of Days Expected _____

Symptoms _____

History _____

Treatment to Date _____

Treatment Plan _____

Medications _____

Tests/Labs _____

Other _____

Provider's Signature _____ Date _____

For prompt review, please have all questions answered. Please fax, attn: Medical Management, to (952)896-1261, along with supporting clinical.

It is our privilege to serve you.