

Fax Cover Sheet

Fax: 888.860.8068
Phone: 510-567-8141

Today's Date:	
Client Name:	DOB:
Hospital Name:	
UR point of contact:	Fax #:
Phone #:	Email:
<input type="checkbox"/> Admit Auth Request: (up to 3 Acute days may be granted) Admission date: _____ Documents required: <ul style="list-style-type: none"> • Complete face sheet or Enrollment form • Review Notes <ul style="list-style-type: none"> ○ Nursing Admission Note (including admission diagnosis) or Documentation of admission 	<input type="checkbox"/> Continued Authorization Request: # Days requested: _____ * (up to 5 Acute, up to 7 Admin days may be granted) Authorization Expires: _____ Documents required: <ul style="list-style-type: none"> • Review Notes <ul style="list-style-type: none"> ○ Documentation from day before authorization expires
<input type="checkbox"/> Informal Expedited Reconsideration of a Denial or Modification with same MD while beneficiary is still hospitalized) (Submit within 1 business day of written notification) First denied date of service(s): _____ Documents required: <ul style="list-style-type: none"> • Updated or additional information 	<input type="checkbox"/> Discharge: Discharge date: _____ Documents required: <ul style="list-style-type: none"> • MD Discharge Summary • TAR
<input type="checkbox"/> MD to MD / also referred to as Peer to Peer or Clinical Consultation (Request anytime from admission until 1 business day after written notification of denial or modification issued while beneficiary is still hospitalized) Reason for consultation: Hospital MD name: Hospital MD email AND contact number: Provide preferred time Hospital MD may be reached: <i>**Please let your Hospital MD know that an unknown or unfamiliar number may be calling during these times.</i> Documents required: <ul style="list-style-type: none"> • Updated or additional information 	

**If a specific # of days is not provided, ACBHD UM will use clinical information to determine. See related instructions.*

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