Clinical Review Form

Member Information

First Name _____ Last Name _____

Medicaid ID # _____ Date of Birth (mm/dd/yyyy) _____

Phone _____ Age _____ Gender: ☐ Male ☐ Female

Facility Information

Facility Name _____ Contact Name _____

Authorization # _____ Phone _____

Admit Date _____ ☐ Inpatient ☐ Observation

Location ☐ ER ☐ Direct Admit ☐ Same Day Surgery ☐ Outpatient Facility

Level of Care ☐ Acute ☐ Intermediate ☐ Critical ☐ Special Care Nurse ☐ NICU Level III ☐ NICU Level IV

Diagnosis _____

Symptoms/Findings/Medical History/Prior Outpatient Treatment _____

_____

_____

Vital Signs (Oxygen Saturation On Room Air) _____ O2 _____

Monitoring (Cardio/Respiratory, ICP, Neuro, Invasive) _____

Diet _____ Activity _____

Abnormal Labs/Diagnostics/Culture Results/Procedures _____

_____

Medications (Dosage, Route, Frequency) _____

_____

Tubes, Drains, Lines _____

IV Fluids (IVGs, Additives, TPN) _____

Discharge Plan _____

_____

_____

Discharge Date _____ Anticipated D/C Needs _____

Barriers to D/C _____

_____

Please fax the completed form to: 1-877-668-2080