Admission Notification

Fax Form to: (651) 662-7006

Telephone: 1-800-528-0934, select option 3

Type of notification (X one): __ Preadmission __Plan-of-care __Continued-stay

Your Info.

You are a (circle one): Clinic or Facility Contact person: ________________________________

Phone #: (______) _______-__________ Fax #: (______) _______-___________

Provider name: ____________________________ Contracting provider #: __ __ __ __ __ __ __ Alpha

NPI #: _______________

Patient Info.

Name: ______________________________________ __ Gender (circle one): M or F

Patient's ID #: (__ __ __) __ __ __ - __ __ - __ __ __ __ Alpha Date of birth: _____/_____/__________

Medical Information

Referring physician ind. #: __ __ __ __ __ __ __ Alpha Name: ____

Referring physician NPI #:__________________

Admitting physician ind.#: __ __ __ __ __ __ __ Alpha Name: ____

Admitting physician NPI #:_________________

Facility #: __ __ __ __ __ __ __ Alpha Name: ____

Admit ICD9 DX code: ___ ___ ___ ___ ___ Admit DX description: _____________________

Secondary ICD9 DX code: ___ ___ ___ ___ ___ 2nd DX description: ________________________

Procedure ICD9 code: ___ ___ ___ ___ Procedure date: _____/_____/________

Procedure description: ____

Secondary ICD9 code: ___ ___ ___ ___ 2nd procedure date: _____/______/_______

2nd procedure description: ____

ADMISSION DATE: _____/______/________ DISCHARGE DATE: _____/______/________

Your medical record # (optional): ____

Medical information (necessary for admissions requiring plan-of-care review):

____

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Internal use:
This is the certificate number for this admission:

#00 ____ ____ ____ ____ ____ ____ ____ ____

Information contained on this facsimile (FAX) message is confidential and intended only for the use of BlueLink TPA medical review. If you are not the intended recipient of this information or the person responsible for delivering it, you are prohibited from disclosing, distributing, copying or acting in reliance upon this information. If you have received this FAX in error, please notify us immediately by telephone at (651) 662-5270 and return all pages to: BlueLink TPA, PO Box 64560, St. Paul, MN 55164-0560. An inadvertent transmittal by FAX does not alter the privileged nature of this communication pursuant to statute or common law.

X16025R03 (12/09)

Tell Me More about……

Preadmission notification (PAN)	When a PAN is required call us as soon as the admission is scheduled or submit the information electronically through our provider web self-service site (www.providerhub.com). Have the following information available. • Subscriber ID & account # • Subscriber name & address • Patient name, birth date, & sex • Admitting physician's name & individual provider # • Admitting DX code • ICD9 surgical procedure code # and narrative, if applicable • Date of surgery, if applicable • Date of admission
Plan-of-care review	Plan-of-care review is required for: • Direct admissions to acute rehabilitation units or facilities and long term acute care units or facilities • Mental health/chemical dependency admissions, including acute care, partial hospital, and residential (behavioral health reviews and uses separate forms) • Workers' Comp. non-emergency admissions • All admissions to nonparticipating facilities Contact us as soon as the admission is scheduled, but no later than two working days after the admission occurs. In addition to what is listed above, have the clinical information supporting the admission. We will complete the plan-of-care review in one working day whenever possible.
Continued-stay notification	Length-of-stay or continued-stay medical necessity review will only be performed on specific cases. Our case managers will collaborate with facility's discharge planners/social workers when high-risk patients are identified.
Contacting us	Call Provider Service Health Care Coordination area at 1-800-528-0934, select option 3. You may fax this form to (651) 662-7006.

Inpatient stay notification/review requirements may change prior to being reflected on this form.