



## Inpatient Clinical Information Request Form

<b>Hospital:</b>	<b>Admission Date:</b>		
<b>Date of Request:</b>	<b>Admission Diagnosis:</b>	<b>Procedures:</b>	<b>Procedure dates:</b>
<b>Member Name:</b>	<b>DOB:</b>	<b>Member ID:</b>	
<b>CeltiCare Case Manager:</b>	<b>CeltiCare Case Manager Phone:</b>	<b>CeltiCare Medical Management Fax:</b> 866-614-1947	

Instructions: In order for CeltiCare to complete this review, please provide the following information (checked items) to the above noted case manager by fax or phone no later than **date:** \_\_\_\_\_ at 12 noon. If you are faxing this information, please complete this form or attach the requested information.

Please Note: Failure to provide requested clinical information by the date and time above may result in administrative denial

Initial Review
  Continued Stay Date From \_\_\_\_\_ to present
  Expected Discharge Date: \_\_\_\_\_

<input type="checkbox"/> <b>Hospital Case Manager Name:</b>	<input type="checkbox"/> <b>Cell phone / beeper:</b>
<input type="checkbox"/> <b>Medical History:</b>	
<input type="checkbox"/> <b>Current mental status:</b>	
<input type="checkbox"/> <b>Current functional status:</b>	
<input type="checkbox"/> <b>Enter InterQual Criteria Set used for review:</b>	
<input type="checkbox"/> <b>Clinical information to support admission:</b>	
<input type="checkbox"/> <b>Clinical information to support continued stay:</b>	
<input type="checkbox"/> <b>IVs, IM Meds:</b>	<input type="checkbox"/> <b>Frequency:</b>

**The following guidelines outline the frequency with which CeltiCare will typically conduct inpatient reviews**

<b>Critical Care</b> <ul style="list-style-type: none"> <li>Initial Review</li> <li>Review every 5 to 7 days until level of care change is imminent</li> </ul>	<b>Intermediate (Telemetry, Specialty unit)</b> <ul style="list-style-type: none"> <li>Initial Review</li> <li>Review every 3 to 5 days until level of care change is imminent</li> </ul>	<b>Acute Medical &amp; Surgical</b> <ul style="list-style-type: none"> <li>Initial Review</li> <li>Review every 1 to 3 days until discharge plan is approved</li> </ul>
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<input type="checkbox"/> Treatment:	<input type="checkbox"/> Frequency:
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<input type="checkbox"/> Consults:	<input type="checkbox"/> Dates:	<input type="checkbox"/> Results:
<input type="checkbox"/> Labs:	<input type="checkbox"/> Dates:	<input type="checkbox"/> Results:

<input type="checkbox"/> Doctors orders (please attach):	<input type="checkbox"/> For requests on discharge for authorization for admission to a Skilled Nursing Facility or Acute Rehabilitation: The following information is required prior to a case manager giving an authorization for an extended care admission. Please send this additional information via fax along with this completed form. <ul style="list-style-type: none"> <li>• Physical Therapy assessment</li> <li>• MD progress notes indicating need for continued skilled services</li> <li>• Discharge medication list</li> <li>• Case management progress note indicating expected plan of care</li> </ul>
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<input type="checkbox"/> Discharge plan:	<input type="checkbox"/> Other :
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