PASSPORT HEALTH ★ PLAN

UTILIZATION MANAGEMENT AUTHORIZATION REQUEST FORM INPATIENT ADMIT

Complete this entire treatment plan to avoid delays in processing your request.
Fax completed request to: (502) 585-7989

Today's Date: ____________________ Member Name: ______________________________ PHP ID: ____________________

Procedure(s) requested with CPT code(s): ____

Inpatient: ______________________________ Requested Date: ______________________________________

Diagnosis: ____

Clinical Information: (Presenting Symptoms & History)

____

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Physical Exam Findings: (Include objective functional assessment, neurological deficits noted, responses to previous treatment, and progression of condition)

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____

Radiologic studies: (Include dates and results)

____

____

Abnormal Labs:

____

____

ER Treatment: (Please include Frequency & Dosage of PRN meds received)

____

____

Current Medications:

NAME OF DRUG	DOSAGE	DATE STARTED

Daily Updates: ____

Consults: ____

Anticipated Discharge Needs: ❑ DME ❑ Home Health ❑ Other: (specify) ________________________________

Provider Information:
Requesting Provider Name: ______________________________ PHP ID Number: ______________________
Facility: ____ PHP ID Number: ______________________
Contact Person: ___________________________ Telephone Number: ______________ Fax Number: ______________

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