INLAND EMPIRE HEALTH PLAN

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REQUEST FOR UM CRITERIA LOG

IPA Name: _____ Log for Year: _____

Date Requested	Date Sent	Sent via: F = fax EM = email GM =ground mail	Name of the Requesting Practitioner or Member	Member Name and IEHP ID #	Line of Business (MC, DSNP, CCA)	Criteria Requested (i.e. InterQual-MRI Brain)	Reason for Request

Legend: MC = Medi-Cal DSNP = DualChoice (HMO D-SNP) CCA = IEHP Covered
F = Fax EM = email GM = Ground