ACUTE HOSPITAL DISCHARGE NEEDS REQUEST

REQUEST INFORMATION

Request Date: ____________ **Requested By:** ____________

Requesting Hospital: ____________

Member Name: ____________

IEHP Member ID: ____________ **Expected Discharge:** ____________

ICD/Diagnosis Code: ____________

REQUESTED SERVICES

☐ HLOC	LOC/Service:
☐ LTAC	LOC/Service:
☐ Acute Rehab	☐ PT ☐ OT ☐ ST ☐ IV:
☐ Post-Acute Skilled	☐ PT ☐ OT ☐ ST ☐ IV:
☐ Post-Acute Custodial	LOC:
☐ Home Health	☐ SN ☐ PT ☐ OT ☐ ST Other/Freq:
☐ DME	HCPCS:

☐ **ORDERS ATTACHED:** Physician orders & clinical documentation are **required** for all services listed above.

*** LOC, Services and/or HCPCS must be completed for each service category requested.*

REQUESTED PROVIDER INFORMATION

Accepting Provider Name: ____________

Provider Address: ____________

Phone: ____________ **Fax:** ____________

Contact Person: ____________ **Confirmed?** ☐ Yes ☐ No

NOTES

Please submit requests directly to the facility assigned IEHP Inpatient Nurse Case Manager.