



Health Care Excel, Incorporated
 Post Office Box 105110
 Jefferson City, Missouri 65110-5110
 Prior Authorization: 800-766-0686
 Facsimile Number: (573) 634-4262

**MO HEALTHNET UTILIZATION REVIEW (UR) PROGRAM
 CONTINUED STAY FAX REQUEST FORM**

Medicare Part A Yes No ***If yes, Date Benefits Ended:** ____/____/____
**Must have benefits ending date or review will not be processed*

Patient Name _____ Date of Birth ____/____/____ Gender M F

Patient Address _____

Telephone Number _____ Participant MO HealthNet Number _____

Attending Physician _____
 First Name _____ Last Name _____

Physician Specialty _____

Physician License Number _____ **OR** Physician MO HealthNet or NPI Identifier _____

Physician Address _____

Telephone Number _____ Fax Number _____

Hospital Name _____

Hospital Address _____

Hospital MO HealthNet or NPI Identifier _____ UR Telephone Number _____

UR Fax Number _____

***MUST INCLUDE ICD-9 CODE ***

Principal Diagnosis, if established _____ ICD-9 Code(s) _____

Additional Diagnosis _____ ICD-9 Code(s) _____

Number of Continued Stay Days Requested _____ from ____/____/____ through ____/____/____

Admission Date ____/____/____ Discharge Date ____/____/____ (if no longer inpatient)

Current Cease Payment Date ____/____/____ Authorization Number _____

Indication(s) for Continued Stay (include pertinent lab and/or x-ray results, IV fluids/medications, med/neb, vital and continued signs and/or symptom, history and discharge plans)

Vital Sign Frequency _____ Neuro Check Frequency _____ Other Monitoring _____

Name of Person Submitting Request (Please print clearly) _____ Date ____/____/____

Telephone Number (Please include extension) _____ Fax Number _____