



Health Care Excel, Incorporated
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 Jefferson City, Missouri 65110-5110
 Prior Authorization: (800) 766-0686
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**MO HEALTHNET UTILIZATION REVIEW (UR) PROGRAM
 POST-ADMISSION URGENT OR EMERGENCY FAX REQUEST FORM**

Medicare Part A <input type="checkbox"/> Yes <input type="checkbox"/> No *If yes, Date Benefits Ended: ____/____/____ *Must have benefits ending date or review will not be processed
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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 ***

Admitting Diagnosis _____ *ICD-9 Code(s) _____

Additional Diagnosis _____ *ICD-9 Code(s) _____

Initial Number of Days Requested _____ from ____/____/____ through ____/____/____

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

Urgent and/or Emergent Condition Necessitating Admission (Include pertinent lab or/or x-ray results, presenting signs and symptoms, vital signs on admission, and the patient's medical history.) _____

Treatment Plan (Please provide a treatment plan for each day requested. Include administration of IV fluids, IV medications, respiratory treatments, and other treatments being provided. Indicate discharge or placement plans, and tentative discharge date, if known.) _____

Vital Sign Frequency _____ Neuro Check Frequency _____ Other Monitoring _____

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

Telephone Number (Please include extension) _____ Fax Number _____