



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

**MO HEALTHNET UTILIZATION REVIEW (UR) PROGRAM
 PRE-ADMISSION 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) _____

Planned Admission Date ____/____/____

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

Indication(s) for Admission (Include pertinent lab and/or x-ray results and significant or unusual risk factors present for patient.)

Planned Procedure(s)

CPT Code(s), if known _____ Date of Surgery ____/____/____

Please indicate medical need and treatment plan, if patient is to be admitted prior to the date of surgery.

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

Telephone Number (Please include extension) _____ Fax Number _____