INPATIENT Notification Form

FAX: 1-801-758-3370

www.StewardHealthChoiceUT.org

Steward Health Care Network

HEALTH CHOICE UTAH

INPATIENT NOTIFICATION (ONLY)

Member Name (Last, First)	Member ID#	DOB	Date of Notification

INPT Admit Source	☐ Emergency Room	☐ Elective Procedure – Prior Auth #
	☐ Alcohol & Drug Treatment Center (ATC)	☐ Direct Admit – Admitting Physician
Admit Type	☐ Inpatient	
	☐ Observation (*Please note – Observation does not require prior authorization)	

Name of Facility		ED Arrival (Date/Time)
Facility Address	**NPI #**	**INPT Admit (Date/Time)**
Contact Person	Direct Phone #	Fax #
Admitting Diagnosis 1 (ICD-10 code)	Admitting Diagnosis 2 (ICD-10 code)	Admitting Diagnosis 3 (ICD-10 code)

Name of Procedure	CPT code 1	CPT code 2	CPT code 3	CPT code 4

*** Providers are required to send medical documentation supporting requested service within 1 business day following INPT admit.**

*** Providers are required to send updated clinical information 24 hours prior to end of days authorized for concurrent review.**

Please fax REQUEST FORM, FACESHEET, and CLINICALS to 1-801-758-3370.

- Failure to provide requested documentation may result in delayed payment of claims and/or denial of requested services/authorizations.
- Medical/Clinical information is evaluated using evidence-based criteria along with local delivery systems and other circumstances to determine appropriateness of requested healthcare services.