CenCal HEALTH™

**CenCal Health**
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# Inpatient Authorization Request

**CONFIDENTIAL PATIENT INFORMATION**

## FOR PROVIDER USE (PLEASE TYPE)

ORIGINAL AUTHORIZATION NUMBER | ADMIT DATE | AUTH. EXP. | EMER ADMIT

PROVIDER NUMBER | PROVIDER PHONE NO.

PROVIDER NAME

PROVIDER STREET/MAILING ADDRESS

PROVIDER CITY, STATE AND ZIP CODE

PATIENT IDENTIFICATION NO. | PEND | SEX | DATE OF BIRTH | AGE

PATIENT NAME | MEDICARE STATUS | OTHER COV

NUMBER OF DAYS REQUESTED | TYPE OF DAYS | RETRO-ACTIVE | DISCHARGE DATE

ADMITTING DIAGNOSIS DESCRIPTION

ACUTE FACILITY DOCUMENTATION:

**HOSPITAL:** To the best of my knowledge the above information is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

X
SIGNATURE OF PROVIDER | DATE / /

Type or print name of responsible physician

Signature of responsible physician | Date / /

**CENCAL HEALTH STAFF** - VALIDATING INFORMATION AND EXPLANATION

CHART REVIEWS

## For CenCal Health Use Only

DENIED

DEFERRED

APPROVED AS REQUESTED

APPROVED AS MODIFIED

DAYS | ACUTE | ACUTE ADMIT | SUB ADMIN VENT | SUB ADMIN N-VENT

DAYS OF THIS HOSPITALIZATION ARE DENIED (SEE COMMENTS)

MEMBER NOTICE OF ACTION

DATES OF DAYS DENIED

RETROACTIVE

CENCAL HEALTH STAFF | I.D. NO. | DATE

BY

CONTROL NUMBER

A1237867

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.