Hospital Intake Form 0524

L.A. Care HEALTH PLAN®

Facility NPI
Contact First Name
Contact Phone Number
Return Fax Number
- -

Member ID
Member Last Name
Member DOB MM/DD/YYYY
/ /
LAC Auth # (if known)

Hospital Priority & Type of Clinical Service Requested – *For Hospital Use Only* !

To ensure prompt and efficient processing, please check appropriate boxes and clearly enter data in each block

Do not submit requests for approval of Observation Level of Care – *Authorization is not required*

Initial Service From Date (MM/DD/YYY)	Primary ICD-10 Code
/ /	.

	ANY Facility Admission *Documentation REQUIRED*		Concurrent Review *Documentation REQUIRED*
☐	**Routine Request**	☐	**Extended Stay Requested** *All Clinical Records + Detailed Data Supporting Continued Stay*
☐	**Urgent / Expedited Request**	☐	**Higher Level of Care (Concurrent Review)** *All Clinical Records + Detailed Data Supporting Higher Level of Care Continued Stay*
☐	**Initial Review** *Facility Face Sheet & All Clinical Records / Supporting Data*	☐	**Transfer Request** *All Clinical Records + Detailed Data Supporting Placement Request*
☐	**Higher Level of Care (Initial)** *Facility Face Sheet & All Clinical Records + Detailed Data Supporting Higher Level of Care*	☐	**Difficult Placement Assistance** *All Clinical Records + Detailed Placement Attempts*

- OR -

	Discharge Planning Notification		
☐	Expected Discharge Date	/ /	
☐	Actual Discharge Date	/ /	
	***REQUIRED* Attachment if Discharging Member** **Please Select One & Include Relative Documentation**		
☐	Discharge Orders	☐	Discharge Plan

Fax to LA Care Health Plan: (877) 314-4957

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