

Hospital Notification of Emergent Admissions



Fax to: 888-800-9005
Keystone First
Patient Care Management Team

Date of Admission: ____/____/____ (Keystone Mercy Health Plan must be notified on the first business day following date of service.)

Member ID #: _____ DOB: ____/____/____ Member Name: _____

Type of Admission

- Inpatient Medical Observation less than 23 hours stay
 Short Procedure Obstetric Observation less than 23 hours stay

Diagnosis/Reason _____ for _____ Admission:

Attending Physician: _____ Keystone First Provider ID #:

Procedures Performed (must be completed for SPU Admissions): _____

Is Member Pregnant? Yes No

EDC: _____ OB Practitioner: _____

For Keystone Mercy Health Plan Use Only

Case #: _____

6087 - UM Disclaimer - Admissions

The case reference number is for **identification purposes only**. Authorization is based on medical necessity and is subject to member eligibility and applicable Plan benefit limitations. This is not a guarantee of payment.

1A01

Member 2

Date of Admission: ____/____/____ (Keystone First must be notified on the first business day following date of service.)

Member ID #: _____ DOB: ____/____/____ Member Name: _____

Type of Admission

- Inpatient Medical Observation less than 23 hours stay
 Short Procedure Obstetric Observation less than 23 hours stay

Diagnosis/Reason _____ for _____ Admission:

Attending Physician: _____ Keystone First Provider ID #:

Procedures Performed (must be completed for SPU Admissions): _____

Is Member Pregnant? Yes No

EDC: _____ OB Practitioner: _____

For Keystone First Use Only

Case #: _____

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Return response by: Fax Phone (This will be returned by the next business day. If not indicated, response will be faxed.)