HOSPITAL ADMISSION FORM

Patient Name:_____

Member ID #:_____

Date of Birth: _____

Facility: _____

Address: _____

Facility Phone #: _____

Person Filling Out Form: _____

Phone #: _____

Fax #: _____

ICD-10 Code/Admitting DX: _____

Date of Admission: _____

Date of Discharge if Applicable: _____

Admission Type (Inpt/Outpt): _____

Referral Number if this is a Scheduled Procedure: _____

Please fax ALL clinicals AND this form to 405-758-4374 or email to concurrentreview@globalhealth.com

Notification of admission must be provided within 24 business hours of a member's admission to your facility.

Do not use the HealthAxis Provider Portal to enter hospital admissions.