Clear Spring Health

Admission Certification Form

Request Date:	**Fax:**
Submitted by:	**Phone:**

Fax Request to 866-611-1957. For questions, please contact: 1-877-364-4566.
Clinical documentation is required for authorization processing, please attach all documents.

Facility:	
Admission Date:	**Discharge Date:**
Patient Name:	**Plan Member ID:**
Date of birth:	**Patient Phone #:**
Patient Address:	

Admission Type:

☑ Acute Rehabilitation ☐ Detoxification ☐ Surgical ☐ LTAC ☐ Maternity ☐ Medical
☐ Observation ☐ Residential – Mental Health ☐ SNF ☐ Psychiatric ☐ Sub-Acute Rehabilitation
☐ Substance Abuse Rehab ☐ Other, please describe: _____

Admission Source:

☐ Elective ☑ Urgent ☐ Emergency Room ☐ Post Amb SX ☐ Transfer ☐ Observation to Inpatient

Attending physician name and phone #:	**Facility MRN #:**
Admission Diagnosis(es) - ICD 10 Code(s):	**Procedure Code(s):**

Maternity:

_____ Single Delivery _____ Multiple Delivery _____ Normal Delivery _____ C-Section

Utilization Review department phone #:	**Utilization Review department fax #:**

ADDITIONAL INSURANCE (IF APPLICABLE)

Primary Insurance:
Policy #:
Group #:
Policyholder:
Effective Date:

Disclaimer: Member must be eligible at the time services are provided. Services must be a covered Health Plan Benefit and medically necessary with prior authorization. An authorization is not a guarantee of payment.