Reset Form

AIR/LTACH ADMISSION NOTIFICATION FORM

FYI: Please submit this form to Aspirus Health Plan upon admission, discharge and whenever there is an update or change within 24 hours. ***Incomplete, illegible or inaccurate forms will be returned to the sender***. Please complete the entire form and submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of the request. Review our provider manual criteria references.

For questions call: 715.631.7443 or 1.855.931.5265

Admission and Concurrent Review: Fax form and relevant clinical documentation to: 715.787.737 or email to: clsintakeMA@aspirushealthplan.com

ADMISSION: ☐ **INITIAL** ☐ **CONCURRENT**	
☐ Acute Rehab Inpatient	☐ Long-term Acute Care Hospitals
Member Admitted to Facility ☐Yes ☐No	
Today's Date:	Date of Admission:

PATIENT INFORMATION:		
Name:		
Member ID:	PMI:	
Address:		
City:	State:	Zip Code:
Date of Birth:	Phone:	
Member Product (required)*:		

ADMITTING FACILITY INFORMATION:		
Facility Name:		
Facility NPI Number (required)*:		
Facility Address:		
City:	State:	Zip Code:
Phone:	Fax:	

ORDERING PRACTITIONER INFORMATION:		
Practitioner Name:	NPI Number:	
Address:		
City:	State:	Zip Code:
Phone:	Fax:	

ORDERING FACILITY INFORMATION:	
Hospital Name:	
Hospital Admissions Date:	Hospital Discharge Date:
Primary Admission Diagnosis (ICD-10) Code* must be a billable code:	

CONTACT PERSON FOR QUESTIONS:			
☐ Admitting Facility		☐ Ordering Facility	
Name:			
Preferred Method of Contact:	◯ Phone	◯ Fax	◯ Email
Phone:	Fax:		Email:

REASON FOR REQUEST (SELECT ONE):
☐ Authorization Request
☐ Benefit Exception
☐ Notification
☐ Out of Network Provider Requesting Network Exception
☐ Pre-Admission/ Pre-Determination

INPATIENT ADMISSION GUIDELINES:

Providers are required to notify Aspirus Health Plan of all inpatient admissions. Some admissions require prior authorization to determine coverage, and some admissions require notification only. All admissions must be medically necessary.

Once the member has been discharged, please notify us of the discharge date.

- Discharge information can be faxed to: 715.787.7317 or email to: clsintakeMA@aspirushealthplan.com

Documentation requirements:

In addition to completing the previous sections of this form, kindly attach documentation that supports the medical necessity of this request. Documentation should include:

- **History & Physical (if available)**
- **Discharge Summary (if available)**
- **Clinical Progress Notes (for concurrent requests)**
- **Medication List**
- **Therapy notes, including level of participation (evaluation and last progress notes)**

Concurrent review:

An ongoing review during the member's stay, to ensure that the continued stay meets established medical necessity criteria. Facility providers are required to submit a concurrent review request when additional days are needed.