



## Inpatient Notification Form

**FYI: Incomplete, illegible, or inaccurate forms will be returned to 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 request. Review our provider manual criteria references.

<input type="checkbox"/> <b>Medical Services</b>	<input type="checkbox"/> <b>Mental Health and Substance Use Disorder Services</b>
Fax form and relevant clinical documentation to: 715.787.7316	Fax form and relevant clinical documentation to: 715.787.7314
For questions, call: 715.631.7412 or 1.855.931.4851	For questions, call: 715.631.7442 or 1.855.931.5264

### MEMBER INFORMATION:

Aspirus ID \_\_\_\_\_

Member Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

### SERVICING FACILITY INFORMATION:

In-Network <input type="checkbox"/>	Out-of-Network <input type="checkbox"/>
Facility _____ NPI Number (required)* _____	
Service Location Address _____	
City, State, Zip _____	
Contact Phone _____	Fax _____

### REQUESTER INFORMATION:

Request Sent By \_\_\_\_\_ Email \_\_\_\_\_

Phone \_\_\_\_\_ Total Pages Faxed \_\_\_\_\_

### ADMISSION DETAILS:

Admit Date	Discharge Date	ICD-10 (Diagnosis Code)
<b>Type of Admission (send discharge summary when applicable):</b>		
<input type="checkbox"/> Inpatient Medical Admission <input type="checkbox"/> Inpatient Mental Health Admission <input type="checkbox"/> Inpatient Substance Use Disorder (SUD) Admission		

**ADDITIONAL INFORMATION:**

**Please include any additional information:**