

Service Plus: Emergent, Urgent & Direct Admissions Authorization Form



For Hospital Use only

Phone: 1-888-372-8633 8 a.m. - 5:00 p.m. M-F	Fax: 1-800-339-3554 Anytime day or night	Fax Clinical notes to 904-858-1359 Anytime day or night
---	---	--

- The hours of operation for phone requests are **8 a.m. – 5:00 p.m.** Monday through Friday only.
- All applicable fields are **REQUIRED**. An incomplete request form will delay the authorization process.
- **Phone or Fax notification is required within 24 hours of admission.**
- **Clinical notes are required with all admissions.**

Member Information			
Last Name	First Name	ID # A	
Date of Birth	Gender F <input type="checkbox"/> M <input type="checkbox"/>	<input type="checkbox"/> Adult <input type="checkbox"/> Pediatric	
Request Date	Date of Admission	Time of Admission <input type="checkbox"/> AM <input type="checkbox"/> PM	
Admitting Diagnosis #1	Admitting Diagnosis #2	Admitting Diagnosis #3	
Description	Description	Description	
<input type="checkbox"/> No Clinical notes available	<input type="checkbox"/> Clinical notes faxed	<input type="checkbox"/> Orders faxed	
<input type="checkbox"/> Discharge Date	<input type="checkbox"/> Discharge Disposition		
Bed Type: <input type="checkbox"/> Medical <input type="checkbox"/> Telemetry <input type="checkbox"/> ICU <input type="checkbox"/> PEDS <input type="checkbox"/> PICU <input type="checkbox"/> Maternity <input type="checkbox"/> Surgical			
Physician: Attending, Admitting, Hospitalist etc.			
Name	Provider #	Tax ID	NPI
Hospital			
Name	Provider #	Tax ID	NPI
UR Telephone	UR Fax	UR Contact Person	
Admission Information			
<input type="checkbox"/> ER Admission	<input type="checkbox"/> Roll Over Admission	<input type="checkbox"/> Acute Rehab Admission	<input type="checkbox"/> Discharge Orders
<input type="checkbox"/> Observation Admission	<input type="checkbox"/> Transplant Admission	<input type="checkbox"/> LTC Facility	<input type="checkbox"/> O/P Request
<input type="checkbox"/> Maternity	<input type="checkbox"/> SNF Admission	<input type="checkbox"/> Transportation	<input type="checkbox"/> Out of Area
<input type="checkbox"/> Transfer (Facility to Facility include name of Hospital)			
<input type="checkbox"/> Other (Please specify)			
Labor and Delivery			
<input type="checkbox"/> Vaginal	<input type="checkbox"/> C-Section	<input type="checkbox"/> Well Baby	<input type="checkbox"/> Sick Baby
			<input type="checkbox"/> Male <input type="checkbox"/> Female
Delivery Date: _____	Time of delivery: _____	Apgar _____ / _____	Weight _____
<input type="checkbox"/> Multi Gestation delivery	A _____	B _____	C _____ D _____
Pediatrician Name: [first, last, (middle initial if available)]			
Additional Information:			