NEIGHBORHOOD HEALTH PARTNERSHIP

AFTER HOURS HOSPITAL PRE-CERTIFICATION FORM

Please fax form to: 800-731-2430

- Please be advised, failure to comply with Utilization Management certification protocol will result in non-payment of your claim.
- Failure to provide clinical information at the time of faxed notification may delay the authorization process.
- Verification of benefits, eligibility, or authorization of a service is not a guarantee of payment. Payment remains subject to all of the terms and conditions of the member's benefit plan, including exclusions and limitations. If this member's coverage has pre-existing condition exclusion, payment will be subject to a pre-existing condition investigation at the time claims are filed.

Patient Information	**Requesting Hospital Information**
Patient Name: _____ ID Number: _____ Patient DOB: _____/_____/_____	Hospital Name: _____ Phone: _____ Fax #: _____ Contact Name: _____
Admit Date: _____ Room #: _____	# of pages of accompanying clinical information: _____

Admit via ER or Direct Admit Type (Inpt/OBS/Outpt):	
Admitting Physician:	
Admitting Diagnosis	
Floor Type (ICU, Telemetry etc.)	

Pertinent Clinical Information

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