Fax the completed form and clinical information to:
Health Tradition Health Plan UM Department
Fax Number: 608.781.9654
Urgent Fax: 608.467.4964

Inpatient Pre-Certification/Notification Form

Supporting clinical documentation, including any progress notes must accompany this form.

All fields are required. Incomplete or illegible information will be returned and not processed.

MEMBER INFORMATION

Patient Name (First, MI, Last)		Date of Birth	Insurance ID#	
Gender	Admission Date	Expected Discharge Date	LOS	Authorization Number (if known)

FACILITY INFORMATION

Hospital/Facility and NPI #		Doctor's Name and NPI #
UR Phone Number	Contact Name	Sender's Fax Number

☐ **PRE-CERTIFICATION** - Clinical information must be faxed with this form.

Diagnosis	Expected Date of Admission
Procedure (if known)/Reason for Admission	

☐ **NOTIFICATION OF ADMISSION** - Clinical information, including progress notes must be faxed with this form.

Diagnosis	Date of Admission
Admission Source	Admission Type

☐ **OB ADMISSION** - Clinical information is not needed for standard 2 day/4 day length of stay.
This form can be sent upon discharge only if it is a standard 2 day/4 day length of stay.

☐ Vaginal Delivery ☐ C-Section

Admission date	Discharge date	Gender	Weight
Baby's Name		Baby's Date of Birth	