INPATIENT ADMISSION NOTIFICATION

Please return below form and clinical documentation to Attn: Utilization Management

Phone: 800-342-6510

Fax: 406-532-1501 or 855-999-4351
BH Fax: 406-532-1503 or 855-999-3897

Mail: Allegiance Benefit Plan Management, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

INFORMATION MUST BE SUBMITTED BY ADMITTING PHYSICIAN

Sent By: Requested Date:

Patient Name:	Participant ID#:	Group ID No.:	Patient Date of Birth:
Provider Name:	Provider Address:	Provider TIN & NPI:	Provider Phone: Provider Fax:
Facility Name:	Facility Address:	Facility TIN & NPI:	Facility UR Phone: Facility UR Fax:
ICD-10 Codes:		CPT Codes:	

Admission Category: ☐Emergent ☐Elective Admission Date:

Admission Level of Care (select the most appropriate):

☐Medical ☐Surgical ☐OBSV>48hrs ☐Maternity ☐Neonatal
☐SNF ☐LTAC ☐Rehabilitation ☐Mental Health ☐Detox
☐Partial Hospitalization Days/week___ Hours___ ☐Residential Treatment (CD) ASAM Level_____ ☐Residential Treatment (MH)

NO REVIEW IS NEEDED FOR OBSERVATION STAYS 48 HOURS OR LESS
OR FOR MATERNITY/NEWBORN STAYS THAT FALL UNDER THE FEDERAL MANDATE

PLEASE PROVIDE THE FOLLOWING REQUIRED INFORMATION:

1. ADMISSION HEALTH AND PHYSICAL EXAM NOTES
2. PROGRESS NOTES ASSOCIATED WITH THIS INPATIENT STAY
3. DISCHARGE SUMMARY, IF AVAILABLE.

UPON RECEIPT OF THE REQUIRED INFORMATION, THE PLAN WILL PROVIDE A WRITTEN RESPONSE TO THE WRITTEN REQUEST FOR REVIEW. PLEASE ALLOW THREE (3) BUSINESS DAYS FOR A RESPONSE.

The benefits available are conditional on the participant's employment status, plan eligibility, payment of premium, amount of benefits remaining, plan provisions and plan exclusions. If information obtained at the time of claim places the service(s) in an excluded category or definition, the claim will not be payable. The benefits quoted are not guaranteed. Final determination of benefits to be paid will be made at the time a claim is submitted for payment, with review of the necessary medical records and other information.