HealthPartners®

Out Of Area Hospital Notification Form

Please fax this completed form to **FAX # (952) 853-8705**

Caller Information:

Name: _____ Phone: (_____)_____ ext: _____

Patient Information:

Patient: _____ ☐Male ☐Female Date of Birth:_____/_____/_____
Last First

HealthPartners ID #: _____ **or** Social Security #: _____-_____-_____

Does the patient have other insurance? ☐No ☐Yes: _____

Admission Information: **Bed Service:** ☐ Med/Surg ☐ NICU ☐ MH ☐ OB ☐ Pediatric ☐ CH ☐ ICU/CCU ☐ Telemetry ☐ Acute Rehab

Admission Date: ____/____/_____

Discharge Date: ____/____/_____

Emergent ☐ **Direct/Urgent** ☐ **Scheduled** ☐

Diagnosis: _____ Dx Code: _____

Procedure: _____ Date:_____/_____ Proc. Code: _____

***Provider Information*:**

Facility: _____ Phone: (_____)_____

Street: _____ UR dept: (_____)_____

City: _____ State: _____ Zip: _____

Facility Federal Tax ID: _____ or NPI # _____

Physician: _____Phone: (_____)_____
Last First

Street: _____

City: _____ State: _____ Zip: _____

Physician NPI #: _____

This box for HealthPartners Office use only: ☐**OOA** ☐CIGNA Facility ☐CIGNA Provider

☐**CareCheck** (precert needed) ☐Inpatient ☐Behavioral Health ☐**Prior Auth Required**

Notification Date: _____/_____/_____ Time: ___:___ Auth #: _____ Initials: _____

Pkg: _____ ADM: __ Product: _____ CAG: _____ Clinic: _____ Effective Date: _____/_____/_____