Inpatient Request to Transfer to Out of Area Facility

Phone: (716) 631-3282 Fax: (716) 631-5329

PLEASE NOTE: If * fields on this request are not completed, delay of determination may result. Please be advised that Independent Health must have the necessary information in order to process the request.

DOES THIS REQUEST REQUIRE EXPEDITED STATUS? ☐**NO** ☐**YES** rationale: _____

Note: Expedited requests are appropriate when time frame could seriously jeopardize the life or health of our member

MEMBER INFORMATION:

***MEMBER ID:** ☐☐☐☐☐☐☐☐☐ **SUFFIX:** ☐☐

***NAME:** _____ **DOB:** _____

Home/Cell Phone: (_____) _____-_____ Address: _____ State: _____ Zip code: _____

TRANSFERRING FACILITY INFORMATION:

***NAME:** _____ **NPI:** *☐☐☐☐☐☐☐☐☐☐*

Referring Physician: _____ **TAX ID:** *☐☐-☐☐☐☐☐☐☐*

Phone number: _____ Case Manager: _____ Phone: _____

Admission Date: _____ Current Level of Care (ED, ICU, etc) _____

Diagnosis/Reason for Transfer: _____

In Network Facilities that have been contacted: _____

Anticipated Transfer Date: _____

RECEIVING FACILITY INFORMATION:

NAME:** _____ **NPI ☐☐☐☐☐☐☐☐☐☐*

Address: _____ **TAX ID:** *☐☐-☐☐☐☐☐☐☐*

Accepting Physician: _____ Phone: _____

Accepting Physician Specialty: _____

DOCUMENTATION:

Attach comprehensive clinical documentation supporting your request for admission or continued stay and *pertinent information such as H&P, consults, lab results, etc*.

UnitedHealthcare® Options PPO Network

Independent Health®