



# CLINICAL NOTIFICATION FORM

Date: _____		Agreement Number: _____	
Plan Name: _____		Member Name _____	
Agreement Period: _____		Patient Name: _____	
Member Type: _____	Retention: _____	Member Number: _____	
<input type="checkbox"/>	<input type="checkbox"/>	Patient Date of Birth: ____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
Amount of Eligible Expenses Paid to Date: \$ _____		<b>If a bill for services has been received:</b>	
Professional \$ _____	Hospital \$ _____	Other \$ _____	Do billed charges exceed R&C? <input type="checkbox"/> Y <input type="checkbox"/> N
Total Amount of Claim Expected: \$ _____			Are there questionable charges? <input type="checkbox"/> Y <input type="checkbox"/> N
Dates of Service: From: ____/____/____ To: ____/____/____		If yes, please explain: _____ _____	

**Diagnosis:**  
\_\_\_\_\_  
\_\_\_\_\_

**Prognosis and Current Treatment Plan:**  
\_\_\_\_\_

**If inpatient (acute, LTAC), name and location of facility**  
\_\_\_\_\_  
\_\_\_\_\_

Is the patient in-network? Y N  
If not, have you negotiated a rate? Y N  
Negotiated rate \_\_\_\_\_  
Expected LOS \_\_\_\_\_

**If member receiving high cost drugs:**

Name of drug \_\_\_\_\_  
Frequency \_\_\_\_\_  
Expected cost per month \_\_\_\_\_  
Drug distributor used \_\_\_\_\_

**Is the member receiving dialysis?** Y N  
Is the dialysis center in-network? Y N  
If not, have you negotiated a rate? Y N  
Negotiated rate \_\_\_\_\_  
Dialysis cost per month \$ \_\_\_\_\_  
Has member been referred for transplant? Y N  
If not, why? \_\_\_\_\_  
Dialysis start date \_\_\_\_\_

**Is the member receiving services out your service area not discussed elsewhere?** Y N  
If yes, have you negotiated a rate? Y N  
Negotiated rate \_\_\_\_\_  
Type of services: \_\_\_\_\_  
\_\_\_\_\_  
**Is outside vendor performing management services?**  
Y N Name \_\_\_\_\_

**Is the member in a NICU?** Y N  
Is the NICU in-network? Y N  
If not, have you negotiated a rate? Y N  
Negotiated rate \_\_\_\_\_ Expected LOS \_\_\_\_\_

**Form completed by:**  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_ Phone \_\_\_\_\_  
Email address \_\_\_\_\_