STATE OF LOUISIANA DHH - BHSF MEDICAL ASSISTANCE PROGRAM

Request for Inpatient Acute Care: Extension, Resubmittal, Reconsideration or Update

Please Print or Type							
LEVEL OF CARE	F			PRE-CERT CASE #			
RECIPIENT ID NUMBER RECIPIE	ENT LAST NAME FIRST I	ΜI	PROVIDE	R NUMBER			
					1		
EXTENSION OF HOSPITALIZATION	SURGICAL PROCEDUR	E SUF	RGERY DATE	REQUEST TY	'PΕ		
ICD-9-CM diagnosis code with description to maximum specificity.	(ICD-9-CM hospital						
	procedure code)						
		1.	/ /	Extension			
				Resubmittal	Ш		
2	2	2	_//	Reconsideration			
				Update			
	3	3	_//	Opuaic			
Date:** IV Medications/IV Fluids/TPN: Include route, rate,							
	frequency,			ciade route, rate,			
TempBP R P							
Bules eximates () Vec () No.							
Pulse oximetry { }Yes { }No O2 sat range: On Room Air							
Oz sat range. On Noom An							
At Baseline							
Diet status:							
Dedictric weight in kilograms							
Pediatric weight in kilograms	Trootmonts	n Indude	routes and f	requency; po med	lo		
Labwork. Include the date cultures were obtaine	that meet c		roules and n	requericy, po med	3		
	that most of	nona					
Comments:							
Comments.							
Actual discharge date:							
**Expected discharge date - all information included on this form is for this date unless noted otherwise.							
I declare the foregoing recipient's medical information is true and correct.							
Reviewer/Contact Person Signature							
- •							

Fax#

Phone#_