In-Patient Notification Report

MEDICA®

Member Information

Medica Member Number:

Member Last Name:

Member First Name:

Member Date of Birth:

Other Insurance?

Facility Information

Facility Name:

Medica 7-Digit Provider Number:

Admitting Diagnosis:

Admission Date:

Admit Time:

ICD-9 Codes:

Admission Source: ___ ER ___ Direct ___ Clinic/MD Office ___ Elective ___ Other Facility

Admission Type: ___ Medical ___ Surgical ___ CCU ___ ICU ___ Pediatrics ___ NICU ___ Rehabilitation

Discharge Date:

Discharge Time:

Discharge Diagnosis:

Discharge Status:
- ___ Routine Discharge to Home
- ___ Short Stay/Observation
- ___ Skilled Nursing Facility
- ___ Intermediate Care Facility
- ___ Other Institution
- ___ Home Health Care
- ___ Against Medical Advice
- ___ Mental Health Center
- ___ Expired

Physician Information

Admitting Physician Last Name:

Admitting Physician First Name:

Medica 7-Digit Provider Number:

Telephone Number: ( ) -

Fax Number: ( ) -

Address:

City:

State:

Zip:

Contact Information

Submitted By:

Department:

Phone Number: ( ) -

Fax Number: ( ) -

Contact Person: (If Different)

Department:

Phone Number: ( ) -

Fax Number: ( ) -

Submit

Forward To:

Medica Provider Data Department

Via Fax: 952-992-3555

Via E-Mail: AdmissionNotificatio@Medica.com

If you have questions about this form, please contact the Provider Data Department:

1-800-247-0153, option 4