

# Inpatient Notification Form

Member Information	<b>Medica Member Number:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	<b>Member Last Name:</b> _____ <b>Member First Name:</b> _____
	<b>Member Date of Birth:</b> _____ <b>Other Insurance?</b> _____
	<b>Facility Name:</b> _____
Facility Information	<b>Medica 7-Digit Provider ID or 10-Digit NPI Number:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	<b>Admission Date:</b> <input type="text"/> <b>Admit Time:</b> <input type="text"/> <b>ICD-9 Codes:</b> <input type="text"/>
	<b>Admission Source:</b> ___ ER ___ Direct ___ Clinic/MD Office ___ Elective ___ Other Facility
	<b>Admission Type:</b> ___ Medical ___ Surgical ___ CCU ___ ICU ___ Pediatrics ___ NICU ___ Rehabilitation
	<b>Discharge Date:</b> <input type="text"/> <b>Discharge Time:</b> <input type="text"/> <b>Discharge Diagnosis:</b> <input type="text"/>
	<b>Discharge Status:</b> ___ Routine Discharge to Home ___ Other Institution ___ Expired ___ Short Stay/Observation ___ Home Health Care ___ Skilled Nursing Facility ___ Against Medical Advice ___ Intermediate Care Facility ___ Mental Health Center
Physician Information	<b>Admitting Physician Last Name:</b> _____ <b>Admitting Physician First Name:</b> _____
	<b>Medica 7-Digit Provider ID or 10-Digit NPI Number:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	<b>Telephone Number:</b> ( ) - _____ <b>Fax Number:</b> ( ) - _____
	<b>Address:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____
	<b>Submitted By:</b> _____ <b>Department:</b> _____ <b>Phone Number:</b> ( ) - _____ <b>Fax Number:</b> ( ) - _____ <b>Contact Person: (If Different)</b> _____ <b>Department:</b> _____ <b>Phone Number:</b> ( ) - _____ <b>Fax Number:</b> ( ) - _____
Submit	<p style="text-align: center;">                     To: Medica Provider Data Department                      Via Dedicated Fax: 952-992-3555                      Via E-Mail: <a href="mailto:Inpatientadmission@Medica.com">Inpatientadmission@Medica.com</a>                      If you have questions about this form, please contact the Provider Data Department:                      1-800-458-5512, option 1.4.1                 </p>