HEALTHWATCH
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# UTILIZATION MANAGEMENT NOTIFICATION FORM

**TODAY'S DATE** _____

**DATE OF SERVICE** _____

_____ **Inpatient or**
_____ **Outpatient**

**Information of Requestor:**

**CONTACT NAME** _____

**CONTACT NUMBER** _____

**Please check:**
**____FACILITY or _____PROVIDER OFFICE**

**PHYSICIAN NAME / ADDRESS** _____

**TIN#** _____ **EMAIL:** _____

**PHONE #** _____ **FAX #** _____

**FACILITY / ADDRESS** _____

**TIN #** _____ **EMAIL:** _____

**PHONE #** _____ **FAX #** _____
**UR PHONE #** _____ **UR FAX #** _____

**PATIENT SS#** _____ **NAME** _____

**DOB** _____ **PT'S PHONE** _____

**CARDHOLDER NAME** _____ **EMP GRP** _____
**CARDHOLDER SS#** _____

**DIAGNOSIS:** _____

| **DIAGNOSIS CODE(S):** | | | | | |
|---|---|---|---|---|---|

**PROCEDURE:** _____

| **PROCEDURE CODE(S):** | | | | | |
|---|---|---|---|---|---|

**STOPLOSS CARRIER** *(if known):* _____

**PPO NETWORK** *(if known):* _____