



**Driscoll Children's Health Plan  
HOSPITAL ADMISSION INFORMATION**

Caller: _____ Ph: _____ Date Notified: _____	
Member Name: _____ DOB/ Age: _____	
ID Number: _____ Facility: _____	
Admitting Physician: _____ Admission Date/ Time: _____	
Diagnosis: _____ ICD.9 _____	
_____ ICD.9 _____	
_____ ICD.9 _____	
Status: Inpatient _____ Observation: _____	UM Contact: _____
PCP: _____	Member Eligibility expires: _____
AUTH. Number: _____	Discharge Date / Time: _____
LOS: _____	

(This section below for DCHP use only.)

CONCURRENT REVIEW: \_\_\_\_\_

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