To: Acute Hospitals

From: IEHP – Provider Relations

Date: June 10, 2020

Subject: **Acute Hospital Discharge Needs Request Form**

Effective immediately, Inland Empire Health Plan (IEHP) will require that Acute Hospitals complete the attached **Acute Hospital Discharge Needs Request** form for all discharge which require authorization.

Utilization of this form will allow IEHP to more effectively support hospital Case Management Teams through streamlined discharge planning and Member discharge processes.

Why use the **Acute Hospital Discharge Needs Request** form?

- Reduce delay in discharges
- Provide support to hospital discharge planning
- Provide more timely authorization of discharge services
- Enhanced continuity of care
- Improved Member outcomes

What discharge services require the **Acute Hospital Discharge Needs Request** form?

- Higher Level of Care
- Acute Rehab
- LTAC
- Post-Acute Skilled Nursing
- Post-Acute Custodial
- Home Health
- DME

This process will apply to all IEHP Members where IEHP is responsible for post discharge needs. Please contact your assigned IEHP Nurse Case Manager for questions and further assistance.

For your convenience, an electronic copy of the Acute Hospital Discharge Needs Request Form can be found on our Provider portal at:
www.iehp.org > For Providers > Provider Resources > Forms > UM/CM.

As a reminder, all communications sent by IEHP can also be found on our Provider portal at: www.iehp.org > For Providers > Plan Updates > Correspondence.

If you have any questions, please do not hesitate to contact the IEHP Provider Relations Team at (909) 890-2054.

Enclosure: Acute Hospital Discharge Needs Request Form

ACUTE HOSPITAL DISCHARGE NEEDS REQUEST

REQUEST INFORMATION

Request Date: ____________________ **Requested By:** ____________________

Requesting Hospital: ____________________

Member Name: ____________________

IEHP Member ID: ____________________ **Expected Discharge:** ____________________

ICD/Diagnosis Code: ____________________

REQUESTED SERVICES

- ☐ HLOC — LOC/Service: ____________________
- ☐ LTAC — LOC/Service: ____________________
- ☐ Acute Rehab — ☐ PT ☐ OT ☐ ST ☐ IV: ____________________
- ☐ Post-Acute Skilled — ☐ PT ☐ OT ☐ ST ☐ IV: ____________________
- ☐ Post-Acute Custodial — LOC: ____________________
- ☐ Home Health — ☐ SN ☐ PT ☐ OT ☐ ST Other/Freq: ____________________
- ☐ DME — HCPCS: ____________________
- ☐ **ORDERS ATTACHED:** Physician orders & clinical documentation are **required** for all services listed above.

*** LOC, Services and/or HCPCS must be completed for each service category requested.*

REQUESTED PROVIDER INFORMATION

Accepting Provider Name: ____________________

Provider Address: ____________________

Phone: ____________________ **Fax:** ____________________

Contact Person: ____________________ **Confirmed?** ☐ Yes ☐ No

NOTES

Please submit requests directly to the facility assigned IEHP Inpatient Nurse Case Manager.