

**Unison Health Plan**  
**Inpatient Review Information**  
Utilization Management Phone #: 1-800-366-7304  
Unison Advantage (Medicare) Phone #: 1-877-333-3457

\*\*Fax completed form to the Utilization Management Department\*\*  
A Unison representative will call with an authorization decision within 2 business days

- |  |                     |
|--|---------------------|
| <input type="checkbox"/> Unison of PA (incl. Adult Basic & Kids) | Fax #: 412-457-1351 |
| <input type="checkbox"/> Unison of DE                            | Fax #: 877-877-8230 |
| <input type="checkbox"/> Unison of OH                            | Fax #: 866-839-6454 |
| <input type="checkbox"/> Unison of SC                            | Fax #: 866-841-9336 |
| <input type="checkbox"/> Unison of TN                            | Fax #: 888-869-3118 |
| <input type="checkbox"/> Unison Advantage                        | Fax #: 866-839-4066 |

Hospital Name: \_\_\_\_\_

Reviewer Name: \_\_\_\_\_ Department \_\_\_\_\_ Phone # \_\_\_\_\_

Fax # \_\_\_\_\_ Voice Mail: \_\_\_\_\_ Pager: \_\_\_\_\_

Member Name: \_\_\_\_\_ Member ID#: \_\_\_\_\_

DOB: \_\_\_\_\_ Other Ins: \_\_\_\_\_ Authorization #: \_\_\_\_\_

**Admitted From:**

ER \_\_\_\_\_ Skilled Nursing \_\_\_\_\_ Direct Admit from Home \_\_\_\_\_ Personal Care Home \_\_\_\_\_ Rehab Facility \_\_\_\_\_

Direct Admit from Dr. Office \_\_\_\_\_ Other \_\_\_\_\_

**Admission Date:** \_\_\_\_\_ **Diagnosis:** \_\_\_\_\_ **Bed Type:** \_\_\_\_\_

Admitting Physician: \_\_\_\_\_

Past Medical History: \_\_\_\_\_

◆ **INITIAL/CONCURRENT REVIEW:** (IV/Subq/PO Meds) EMERGENT ADMISSION-Plan must be notified with clinical information within 48 hrs-unless otherwise contracted.

Clinical Symptoms, vital signs, pertinent abnormal/labs/Test results

\_\_\_\_\_

IV Medication (name of drug, medication dose & freq) \_\_\_\_\_

Subq Medications: \_\_\_\_\_

Pain Medications – How Often Administered \_\_\_\_\_

IV Fluids – NPO \_\_\_\_\_ Rate \_\_\_\_\_ Additives \_\_\_\_\_

◆ **PO Medication Adjustments** ie., Coumadin Amiodarone, Digoxin

\_\_\_\_\_

◆ **Respiratory Checklist:**

O2 \_\_\_\_\_ Rate \_\_\_\_\_ C-Pap \_\_\_\_\_ \*\*Vent \_\_\_\_\_ PIP/Tidal Volume \_\_\_\_\_ # of hours on vent \_\_\_\_\_

Nebulizer tx: \_\_\_\_\_ Frequency \_\_\_\_\_ Chest PT \_\_\_\_\_ Suctioning \_\_\_\_\_ Chest Tubes \_\_\_\_\_

◆ **Miscellaneous Checklist**

Wound Care \_\_\_\_\_ Size \_\_\_\_\_ Dressing type \_\_\_\_\_ Location \_\_\_\_\_

Neurochecks \_\_\_\_\_ Frequency \_\_\_\_\_ Monitoring \_\_\_\_\_ Fetal \_\_\_\_\_

Cardiac \_\_\_\_\_ Dialysis \_\_\_\_\_ Accuchecks \_\_\_\_\_ Frequency \_\_\_\_\_

◆ **Discharge Planning**

Lives Alone \_\_\_\_\_ With Family \_\_\_\_\_ Home \_\_\_\_\_ Other \_\_\_\_\_

Skilled Facility \_\_\_\_\_ MA 51 \_\_\_\_\_ Rehab \_\_\_\_\_ Rehab Evaluation \_\_\_\_\_ Options Initiated \_\_\_\_\_

(Requires Prior Auth) (MA 51 Applies to PA ONLY) (Requires Prior Auth)

◆ **Discharge Needs:** (Prior Auth Required for All Services)

Skilled Nursing Visits \_\_\_\_\_ PT \_\_\_\_\_ OT \_\_\_\_\_ SPEECH \_\_\_\_\_

Durable Med. Equip. \_\_\_\_\_ IV Medications \_\_\_\_\_

◆ = Required Clinical Information

\*\* = Please attach Respiratory Flow Sheets