Notification of Admission for Low-Income Health Plan (LIHP) / Riverside County Health Care (RCHC) Funding

Hospital/Facility Name: _____

Hospital/Facility Address: _____

City: _____ State_____ ZIP: _____

Hospital/Facility Phone#: _____ Fax #: _____

This is notification regarding the admission of:

Patient Name: _____

DOB: _____ SSN#: _____ Med Record# _____

Admission Date: _____ Discharge Date:_____

Number of Days Requested: _____

Please review the attached records for LIHP/RCHC funding. If you have any questions, please contact:

_____

(Hospital Contact Name and Phone Number)

RCDMH, QI Inpatient Authorization and Appeal Unit, please complete the section below and return by fax to (_____)_____-_____.

(Hospital Designated Fax)

Riverside County Use Only
Acute Days Approved: _____ to_____
Admin Days Approved: _____ to_____
Acute/Admin Days Denied: _____ to_____
Notes: _____ _____
_____
_____
_____
_____ _____
QI Inpatient Signature Date
_____
QI Inpatient Printed Name

CONFIDENTIAL PATIENT INFORMATION: SEE CALIF.W&I CODE 5328