MEDICAL MUTUAL®

Inpatient General Fax Form

***** Please note when submitting this form, include Clinical information. *****

Please fax to: 1 800-517-2583

(Check All That Apply)

☐ Admission ☐ Continued Stay ☐ Discharge Notification ☐ Acute Hospital ☐ Elective Inpatient

☐ Emergency ☐ Skilled Facility ☐ Acute Rehab

Case # (If applicable): #________________________

Facility Name: ____

Facility Tax ID#_____________________ Facility NPI#___________________

Facility Servicing Address: __________________________ City: _________ State: _______ Zip: _____

Attending/Admitting Physician Name: ____

NPI #: _____________________________ Admitting Dr. Specialty: ______________________________

Physician address same as facility? ☐ Yes ☐ No

If "No" state full address ____

Date of Admit: ________________ Date of Discharge (if applicable): _______________

- Inpatient Elective Procedure Code is required: CPT Code(s) _________ _________ _________

Diagnosis Codes: ________ - _________

Contact Information: ____

Fax Back #: _____________________ Phone #: ____________________

Member Name: ___________________________________

Policy/Member ID#: ___________________ D.O.B: _____ / ______/ _____

Additional Information:

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