

HOSPITAL INQUIRY

PROVIDER:		DATE:	
LEVEL OF URGENCY	HIGH: <input type="checkbox"/> Enter Reason _____	LOW: <input type="checkbox"/>	
TYPE OF INQUIRY	PROVIDER: <input type="checkbox"/> FRC: _____	CASE # (IF KNOWN) _____	
RELEASE OF INFORMATION	YES: <input type="checkbox"/> ABCDM 228 NO: <input type="checkbox"/>		
AUTHORIZED REPRESENTATIVE (AR)	MC 382 <input type="checkbox"/> or SAWS2Plus <input type="checkbox"/> or SSApp <input type="checkbox"/> and MC 383 <input type="checkbox"/> AR FULL NAME(S) _____		
PATIENT INFORMATION (IF KNOWN)	LAST _____	FIRST _____	MI _____
	SSN _____	CIN _____	DOB _____
INFORMATION REQUESTED/Additional Comments (EX. CASE STATUS)	_____		
CHANGE IN CIRCUMSTANCE:			
ADD A PERSON, ADDRESS CHANGE, ETC.	<input type="checkbox"/> ADD A PERSON NAME: _____ DOB: _____ <input type="checkbox"/> ADDRESS CHANGE: _____ <input type="checkbox"/> INCOME CHANGE <input type="checkbox"/> New Hire <input type="checkbox"/> No Income <input type="checkbox"/> OTHER: _____		
COUNTY RESPONSE:			
PROVIDER INQUIRY: <input type="checkbox"/> ELIGIBLE/CIN: _____ <input type="checkbox"/> NOT ELIGIBLE			
ACTIVE CASE: YES: <input type="checkbox"/> CASE # _____ NO: <input type="checkbox"/> DENIED/CLOSED _____ DATE _____ REASON: _____ MUST REAPPLY YES: <input type="checkbox"/> NO: <input type="checkbox"/> RESCIND/DISPO DATE _____		CASE STATUS: PENDING: <input type="checkbox"/> DISCONTINUED: <input type="checkbox"/> _____ REASON _____ GOOD CAUSE GIVEN: YES: <input type="checkbox"/> NO: <input type="checkbox"/> MUST REAPPLY 90 DAY CURE DATE _____ RENEWAL MONTH _____ RETRO APPLICATION DATE(S) _____	
PENDING/CURE VERIFICATIONS NEEDED			REQUIRED BY _____
ADDITIONAL COMMUNICATION	_____		
COUNTY WORKER NAME:		DATE:	

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