Riverside University HEALTH SYSTEM Behavioral Health

Attachment K

Notification of Admission for Indigent 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 indigent funding. If you have any questions, please contact:

_____

(Hospital Contact Name and Phone Number)

RUHS-BH QI Inpatient Program, 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