



Promedica Peer to Peer Form



To be completed by UR Nurse/ Payer Specialist:

Hospital: _____ Tax ID: _____ NPI: _____

Name: _____ Age _____ DOB: _____

Insurance Plan: _____ Policy ID: _____ Ref no: _____

Admission: () Emergency () Elective Admission Date: _____

Level Of Care: () Med Surg () Intermediate () ICU

Insurance Physician No:	Timeframe: () 24 hrs () 48 hrs	
Length of Stay	Anticipated Dc Date:	No of Denied Days

Reason for Denial: _____

UR Comments:

Diagnosis: _____

UR Nurse: _____ ph no _____ Date: _____

To be completed with Physician Input

YES NO

- Does the pt's condition require an INPT stay? () ()
- Are treatments and services being rendered that can only be provided in an INPT setting? () ()
- Is discharge planning in progress? () ()
- Could services be provided more efficiently as suggested by the payor? () ()
- Can Physician documentation justify an INPT stay? () ()
- Are you willing to do a P2P to get the Inpt stay approved? () ()
- Reason to Appeal: _____

8. Called at: date /_/__ time ____ Am/Pm Call returned at _____ Am/ Pm Spoke to: Dr _____

9. Outcome of call () Approved by payor () Denied by payor as INPT () will Accept OBS and facilitate Dc Asap

10. Reasons for Denial/ Approval: _____

11. If still Denied , which options will you recommend? () Consider a written Appeal () Refer to Physician Advisor

12. Peer to Peer done by Physician : _____ Date: _____

Please return form to UM Nurse at fax no: -419-480-6888 Or email UM-----

Or call UM Nurse at -----