Change in Condition Form

Purpose of this form: If our member is in denied status at your facility and has a medical change in condition where they would meet InterQual criteria, please return this form for reconsideration of the case.

Please **fax** this form to **1-844-965-0317** as a cover sheet or page 1 and associated clinicals within 5 business days of change in condition. If you have any questions, please call Ambetter from Coordinated Care Corporation at 1-833-661-0642.

Note: All Fields Required

Date: Auth #: Admission Date:

Member Name: DOB:

Denied as of:

Date of change in Medical Condition:

Details of change in Medical Condition including level of care (ICU, Intermediate, or Acute):

Please submit clinicals (Medical Records) from **date of change in medical condition to current date** with this form, including:

Daily MD Progress notes
Doctor's Orders
MAR / IV Fluid Rates
Lab / Radiology Results
Plan of Care: MSW or Care Management notes for discharge planning
Level of Care (Acute, Intermediate, ICU)
PT/OT/ST Progress notes (If member is being transferred to a SNF or Inpatient Rehab)