



Upon completion of this form **please fax to 1-833-966-0769** or upload this document to your request via the provider portal at Homestatehealth.com

Facility Name	
Facility NPI #	
Contact Person Name	
Phone #	
Fax #	
Level of Care / CPT Code Requested	
Modifiers	
Admit Date	
Member Name/DOB	
Attending Physician Name / #	
Other Insurance	
<i>(if yes, please include policy information)</i>	
Guardian name and phone #	
RCST/phone #	
Dx at Admission	
Medical Issues	

State Custody/Foster Care or DYS	Yes ☐	No ☐	
IA attached	Yes ☐	No ☐	N/A ☐
Recommendation from IA is RTC	Yes ☐	No ☐	
CS9 Attached	Yes ☐	No ☐	
Adoption Subsidy	Yes ☐	No ☐	
<i>If Adoption Subsidy, the Adoption Subsidy worker is aware of Admission</i>	Yes ☐	No ☐	N/A ☐
Court Commit /Ordered: <i>If yes, attach court order</i>	Yes ☐	No ☐	
What is the discharge plan at admission:			
Comments (optional):			