

# Medical Financial Consulting

## CHRONIC ILLNESS MANAGEMENT FORM

Date requested: \_\_\_\_\_ Requested by: \_\_\_\_\_  
Ins. Co: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
Patient Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male: \_\_\_\_\_ Female \_\_\_\_\_  
State of Residence: \_\_\_\_\_ (Language) English: \_\_\_\_\_ Spanish: \_\_\_\_\_  
Hospital Name: \_\_\_\_\_ Room Number: \_\_\_\_\_  
City / State: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_  
Admission Date: \_\_\_\_\_ Expected Discharge Date: \_\_\_\_\_  
Original LOS Approved: \_\_\_\_\_ Additional Days approved: \_\_\_\_\_  
Attending Physician: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_  
Primary Diagnosis: \_\_\_\_\_ Co-morbid conditions: \_\_\_\_\_

---

Surgical Procedures: \_\_\_\_\_

### Reason for Referral:

\_\_\_\_\_: Repeat Hospitalization  
\_\_\_\_\_: Excessive Length of Stay  
\_\_\_\_\_: Patient Not Meeting Criteria  
\_\_\_\_\_: Discharge Planning Needed

### Brief Summary of Case:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Requestor's Signature Title Date Phone # (incl. Ext.)

Please make sure to include a copy of the signed representation agreement and patient's authorization to release medical records, if available.