

Notification of Admission for Low-Income Health Plan (LIHP) / Riverside County Health Care (RCHC) 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 LIHP/RCHC funding. If you have any questions, please contact:

(Hospital Contact Name and Phone Number)

RCDMH, QI Inpatient Authorization and Appeal Unit, 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	