

Patient Advocates, LLC  
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Pre- Notification Worksheet

Today's Date	
Patient Name	Patient ID #
Representative:	
Phone Number:	Fax Number:
Name of Facility:	
Federal Tax ID:	
Address:	
Name of provider:	
Location of service:	
Check one <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> OBS MRI/CT/PET <input type="checkbox"/> Diagnostic <input type="checkbox"/> Pre-op <input type="checkbox"/> Other	
Diagnosis and ICD-9 code:	
Procedure and CPT code:	
Date of service:	
Name of the Primary Care Physician	Phone Number:
Who referred the patient for services	Phone Number:
Comments:	
FOR INTERNAL USE ONLY:	
Entered By:	Date entered:
Follow up Actions: <input type="checkbox"/> Letter <input type="checkbox"/> Educational Materials <input type="checkbox"/> TC to pt / provider	
Date of Next NL Follow Up:	
Acute Care Board: <input type="checkbox"/> Yes <input type="checkbox"/> No	

UR/CM Department:

Phone Number:

Referred to CM:  Yes  No

Notified on Date:

12/05