

KePRO Inpatient Psychiatric Continued Stay Review

Submit fax request for Continued Stay to: 1-877-OKBYFAX (877-652-9329).

1. PA Number (if available): 11 digits (ex.12345678901)	2. Date of Continued Stay Request:
3. Enrollee Last Name:	4. Enrollee First Name:
5. Case ID Number: 9 digits with dashes (ex. 07000-0000)	6. Enrollee Medicaid ID Number: 12 digits (ex. 123456789012)
7. Facility Name & ID Number:	8. Original Admission Date For This Stay: (mm/dd/yyyy) _____/_____/_____ Last date of service reviewed (mm/dd/yyyy) _____/_____/_____
9. Number of Days being requested (i.e. 5)	10. Corresponding Dates (i.e. 10-01-07 thru 10-05-07) From (mm/dd/yyyy) Thru (mm/dd/yyyy) _____/_____/_____ - ____/____/_____
11. PA Service Type: <input type="checkbox"/> 0093 EPSDT Freestanding Psychiatric Facility <input type="checkbox"/> 0401 Acute Inpatient Psychiatric	
12. Severity of Illness / Safety Risks / SI / HI :	

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13. Intensity of Service / Medication Changes / Adjustments:

14. Changes to Treatment Plan:

15. Other:

1. Contact Name: _____
2. Contact Telephone Number: _____
3. Contact Fax Number: _____

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INSTRUCTIONS FOR ELECTRONIC FAX FORM

www.dmas.kepro.org
www.dmas.virginia.gov

1. **Include Prior Authorization Number (if this available)**
2. **Date of Continued Stay Request** - this will be the date you are submitting the Continued Stay to KePRO.
3. **Enrollee Last Name**
4. **Enrollee First Name**
5. **Case ID Number** – from iExchange or your fax back notification
6. **Enrollee Medicaid ID Number**
7. **Facility Name & ID Number**
8. **Original Admission Date** – for this stay enter the date the patient was admitted to your facility for this stay.
9. **Number of days being requested (i.e. 5)**
10. **Corresponding Dates (i.e. 10-01-07 thru 10-05-07)**
11. **PA Service Type: 0093 0401**
12. **Severity of Illness / Safety Risk / SI / HI**
13. **Intensity of Service / Medication Changes / Adjustments** – list all changes and adjustments since the last review.
14. **Changes to Treatment Plan** – list all changes and additions to the patient’s treatment plan.
15. **Other** – list any other reasons, circumstances, clinical indicators why this stay should be continued.