

Harmony HealthCare
Concurrent Review Form

Admission Date:	<input type="text"/>	Last Covered Day (Date)	<input type="text"/>				
Patient Name	<input type="text"/>	Date of Birth:	<input type="text"/>	Age:	<input type="text"/>		
Home Address:	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>	Zip Code	<input type="text"/>
Primary Insurance Coverage:	<input type="text"/>	Insurance Identification #:	<input type="text"/>				
Secondary Insurance Coverage:	<input type="text"/>	Insurance Identification #:	<input type="text"/>				
Family Contact	<input type="text"/>	Relationship	<input type="text"/>				

PRIMARY

Diagnosis
Specifiers: Diagnostic Code: _____
(Severe, Moderate) DC: 0-3R: _____
Features:
(Recurrent, Psychotic)

Identified Issues:

1. _____
2. _____
3. _____

SECONDARY

Diagnosis
Specifiers: Diagnostic Code: _____
(Severe, Moderate) DC: 0-3R: _____
Features:
(Recurrent, Psychotic)

Identified Issues:

1. _____
2. _____

Clinical status since last review (check appropriate box)

<input type="checkbox"/>	Unchanged
<input type="checkbox"/>	Worse
<input type="checkbox"/>	Improved

Explanation:

Currently dangerous to self or others:

<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
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Explanation

Currently unable to care for self:

<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
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Explanation

Currently able to plan for safety:

<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
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Explanation

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Patient Name

Date of Birth:

Age:

Medication changes since LAST review:

Please explain the rationale (medical necessity) for treatment to continue in an inpatient versus an outpatient setting:

Projected Discharge
Date

Attending Physician

After Care Plan:

Completed by:

Date

Title / Position

Important: This form must be filled out completely and the clinical information contained herein must be clear and concrete. It must be received by Harmony HealthCare before 11:00 AM of the last approved day and it must convey pertinent observations gathered during the 24 hours preceding its submission. This form must be faxed to (702) 471-0154. Receipt of the completed form by Harmony HealthCare does not constitute guarantee of approval or payment.

Date Received

Approved

Send Up for Review

of Days

Date

Notes / Explanation:

Reviewed by:

Date

Title / Position