GAMP Request for Admission/Continued Stay Authorization

Date: _____ **Inmate Transferred From:** ☐ HOC ☐ Milwaukee County Jail

Patient: _____ **DOB**: _____
Last Name First Name

SSN: _____ **Hospital:** _____

_____
Contact Person **Contact Person's Telephone number** **Contact Pers**

Admission Date: _____ **Time**: _____ **Admission Diagnosis**: _____

_____

Pertinent Clinical Data: _____

Procedure Performed (if applicable): _____ Date: _____

This form is required within three working days of the patient's hospital admission.

Failure to respond in a timely manner will result in denial of payment.

Date	Severity	Intensity

NOTE: For continuing authorization, fax this form with SEVERITY and INTENSITY COMPLE

If severity and intensity are completed on this form and indicate the patient has acute care needs, GAMP will respond with an authorization number and authorized days. Any deviation from the norm will be clarified in writing and faxed to the provider.

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(To be completed by GAMP utilization Management Staff)

Control # EA_____ H_____ U_____

Authorized Length of Stay

Days	To	Days	To

GAMP Eligibility	
	Security. Needs Notification
	Security Notified
	T-19 Letter Sent
	T-19 Received
Booking #	
WPS - SCLO	
LOS	DA

AUTHORIZATION FOR ADMISSION DOES NOT CONSTITUTE APPROVAL OF GAMP COVERAGE

Fax form to 289-8516 Utilization Management : (Telephone # 289-6731)