HOSPITAL TRANSMITTAL FOR DAY OUTLIER REQUEST

PATIENT NAME-(Last, First)

ADMISSION DATE ▶

In order to facilitate the review of day outliers, the hospital must check (✔) below that the required documents are included with the outlier request being submitted to the Department.

☐ A. APPROPRIATE ADMISSION CERTIFICATION/OUTLIER REQUEST FORM

☐ 1. Elective Admissions

a. A copy of the "Place of Service Review Notice"
***Note: "Requested Outlier Days" must be completed**

– OR –

b. A "Day Outlier Request for Cases Exempt from the PSR/DRG Process" form
***NOTE: Item 2 must be completed (outlier days requested).**

☐ 2. Urgent or Emergency Admissions

a. A copy of the "DRG/CHR Certification Notice"
***Note: "Requested Outlier Days" must be completed**

– OR –

b. A "Day Outlier Request for Cases Exempt from the PSR/DRG Process" form
***NOTE: Item 2 must be completed (outlier days requested).**

☐ B. HOSPITAL CLAIM ADJUSTMENT OR INVOICE
***Note: Must be original and on one page**

☐ C. COPY OF REMITTANCE ADVICE SHOWING EITHER THE BASE DRG PAYMENT OR THE MOST RECENT INTERIM BILL PAYMENT

☐ D. HOSPITAL UTILIZATION REVIEW COMMITTEE COMMENTS ON HOSPITAL LETTERHEAD STATIONARY

☐ E. COPY OF **COMPLETE** INPATIENT MEDICAL RECORD

All documents for this case, including the final claim adjustment or invoice and this transmittal, should be securely packaged and mailed to:

Department of Public Welfare
Division of Medical Review
DRG Outlier Review Section
PO Box 8171
Harrisburg, PA 17105-8171

or overnight to:

DPW - Division of Medical Review
DRG Outlier Review Section
DGS Annex Complex
Cherrywood Building #33
Beech Drive
Harrisburg, PA 17110

Without the complete documentation, the Division of Medical Review cannot review your outlier request in a timely manner.

NAME OF HOSPITAL PERSON TO CONTACT ON THIS REQUEST

TELEPHONE NUMBER

HOSPITAL NAME

MA 116 9/06