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| **IPA Name** |  | **Date Submitted** |  |
| **Submitted By** |  | **Contact Number** |  |

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| **Member Name** | **Member ID** | **Age / Gender** | **Facility Name** | **Admission /****Enrollment Date** | **Attending Physician** | **Clinical Summary** **(e.g. Presenting DX,** **Co-morbids/complications resulting in extended stay)** | **Discharge Plan** | **If out-of-area/network, explain?****\*See Legend** | **Comments** |
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***Please fax reviews on day 20 and weekly thereafter to 909-477-8553.***