HUSKY HEALTH
CONNECTICUT

P.O. Box 5005 • Wallingford, CT 06492
1.800.440.5071 • www.ct.gov/husky

INPATIENT REQUEST FORM
ACUTE REHABILITATION AND CHRONIC DISEASE HOSPITAL (CDH)

Please check one: ☐ Acute Rehab Admission ☐ CDH Admission

Member's Name: ______________________ Member's DOB: ______________________

Member's ID #: ☐☐☐☐☐☐☐☐☐ Plan: HUSKY A ☐ B ☐ C ☐ D ☐

Date of Request: ______________________

Anticipated Number of Days: ______________________

Anticipated Date of Admission: ______________________

Acute/CDH Facility Name: ______________________

Acute Rehab/CDH Billing CMAP ID: ______________________

Diagnosis: ______________________

Diagnosis Code(s): ______________________

Admitting Provider's Name: ______________________

Admitting Provider's CMAP ID: ______________________

Phone: ______________________ Fax: ______________________

ALL fields MUST be filled out in order to process request.

Clinical information including proposed treatment/intervention plan must accompany this form.
Please fax request and clinical information to 203.774.0551

****PLEASE ALLOW 2 BUSINESS DAYS FROM RECEIPT OF ALL CLINICAL INFORMATION TO PROCESS REQUEST****