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

INPATIENT SURGERY/PROCEDURE REQUEST FORM

Member's Name: _____ Member's DOB: _____

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

Date of Admission: _____ Anticipated Number of Days: _____

Hospital: _____

Billing Hospital CMAP ID: _____

Name of Surgery/Procedure(s): _____

Procedure Code(s): _____

Diagnosis Code(s): _____

Surgeon/Admitting MD: _____

Surgeon/Admitting MD NPI Number: _____

Name of Contact: _____

Phone: _____ Fax: _____

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

Clinical notes must be included to process request.
Please fax request and clinical information to 203.265.3994.

****PLEASE ALLOW 5 BUSINESS DAYS FROM RECEIPT OF ALL CLINICAL INFORMATION TO PROCESS REQUEST****