HEALTH SYSTEMS

Bed Hold Request Form

Provider Name: **Date**:

Consumer Information:	
Name:	
DOB:	SSN:

Treatment Details:
Date of Admission:
Provider Program Type/ Service Description:
Name of facility Consumer transferred to:
Date leave of absence began:
Reason for Transfer/Leave of absence: Psychiatric Emergency
Bed Hold Request for Number of Days:

[**Please submit all bed hold requests to your network manager via fax or encrypted email.**]

Contact Information:			
Agency Representative	Phone	Fax	Email
LSF Health Systems [Please send all bed hold requests to your network manager]	904-900-1075	904-900-1628	[Please send all bed hold requests to your network manager via encrypted email]
Provider Contact			
Receiving Facility			
Community Case Manger (if applicable)			
Parent/Guardian (if applicable)			

_____ _____

Provider Representative Signature LSF Health Systems Signature, **Authorizing *bed hold***