HEALTH SYSTEMS

Continued Stay Request Form

Provider Name: **Date**:

Client Information:	
Name:	
DOB:	Client ID #:

Treatment Details:
Date of Admission:
Provider Program Type/ Service Description:
Justification for Continue Stay Request Past 90-Days:
Anticipated Date of Discharge:

[**Please submit all continued stay requests to your network manager and Meghan Riley-Reynolds via encrypted email.**]

Contact Information:	Phone	Fax	Email
Agency Representative (Enter Name of Contact Person)			
LSF Health Systems [Please send all bed hold requests to your network manager]	904-900-1075	904-900-1628	[Please send all continued stay requests to your network manager and Meghan Riley-Reynolds via encrypted email]
Provider Contact			

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Provider Representative Signature

LSF Health Systems Signature, **Authorizing *continued stay***