# Information for Certification Request

**COMMONWEALTH OF PENNSYLVANIA**  
**DEPARTMENT OF PUBLIC WELFARE**

## DEPT. REVIEWER

### PSR  DRG  
1st REQUEST  ADD. INFO  SETTING CHANGE  EXTENSION REQUEST

### Recipient/Provider Information

1. **Recipient Number**  
2. **Recipient Name**  
3. **Birthdate**  
4. **Facility PA PROMISe™ Provider Number** (13 digits)  
5. **Facility Name**  
6. **Practitioner PA PROMISe™ Provider Number** (13 digits)  
7. **Practitioner Name**  
8. **Late Pickup Elig. Date**  
9. **Date Facility First Notified of Elig. and How Notified**  
10. **Practitioner License #**  
11. **Person Making Request**  
12. **Telephone Number of Person Making Request**

### Admission Information

13. **Admission Date**  
13. **Admission Class (Emergency or Urgent) / Admitted to What Floor or Unit?**

14. **Admitting Diagnosis Codes**  
   A. **ICD-CM Code Descriptions**  
   B.  

15. **Secondary Diagnosis Codes**  
   C. **ICD-CM Code Descriptions**  
   D.  

16. **ASC/SPU Only - HCPCS Procedure Code** (5 digits)  
17. **Inpatient Only - ICD Procedure Code**

18. **Procedure Performed**

19. **Number of Extended Treatments Requested (ASC/SPU Only - Maximum of 10)**

20. **What are the Indications for Surgery/Treatment? Describe any pathology and justification for setting**

21. **Describe any attempts that have been made to treat this condition on an outpatient basis**

22. **ER Date and Time**  
23. **Admission Date**  
24. **Discharge Date if Applicable**

### Prior Admission Information

25. **Prior Admission Date / PA # with Outcome**  
26. **Prior Admission Discharge Date**

27. **Transfer Information / PROMISe™ Facility Number of Transferring Facility**