ELIGIBILITY DETERMINATION FORM

PATIENT NAME

PATIENT ADDRESS

PATIENT MEDICAL RECORD NUMBER OR HOSPITAL PATIENT NUMBER	DATE OF ADMISSION

DIAGNOSIS

WAS HOSPITALIZATION DUE TO

ACCIDENT ☐ YES ☐ NO OCCUPATIONAL INJURY ☐ YES ☐ NO

HOSPITAL NAME	PROVIDER NO.

HOSPITAL ADDRESS

HOSPITAL CONTACT PERSON	TELEPHONE NO.

HOSPITAL WILL BE NOTIFIED OF ACTION ON THIS REQUEST VIA A COPY OF FORM PA 162

HOSPITAL REPRESENTATIVE SIGNATURE

DATE

MA 314 4/06

ORG. COUNTY BOARD OF ASST.