ADVANCED IMAGING
REQUEST FOR REVIEW FORM

SUBMITTED BY

Contact:

Phone #: Fax #:

PATIENT INFORMATION

Name: Claim #:

Date of Birth: Date of Injury: Social Security #:

REQUESTING PHYSICIAN INFORMATION

Provider Name: L&I Provider ID#:

Dates of Service: Requested Length of Stay:

IMAGING

Facility Name: L&I Provider ID#:

Facility Phone #:

ICD9-CM Diagnosis Code(s): CPT Code **(only 1 per request)**:

Side of Body: ☐ Right ☐ Left ☐ Bilateral ☐ N/A

Body part requested for imaging:

(NOTE: a separate questionnaire is required for each body part)

Questionnaire attached: ☐ Yes ☐ No Number of Pages:

Please submit this information by one of the following:

INTERNET (PREFERRED)

This form is not necessary for internet review requests.

Login at: http://www.onehealthport.com/services/Qualis_prere2.php

PHONE:

800-541-2894

FAX:

877-665-0383

MAIL:

PO Box 33400

Seattle, WA 98133-0400