Group A Providers

OUTPATIENT PROCEDURE NOTIFICATION

**NOTE: Certain procedures are excluded from this study. Please see provider bulletin for details (PB 05-09).

PATIENT INFORMATION

Name: ______________________________ Claim #: ______________________

Date of Birth: __________ Date of Injury: ___________ Social Security #: _______________

REQUESTING PHYSICIAN INFORMATION

Physician: ____________________________ L&I Provider #: ___________________

Office Contact: ____

Office Phone #: _________________________ Office Fax #: _____________________

Date of Service: _________________________

Facility Name: __________________________ L&I Provider #: ___________________

Facility Phone #: ________________________

PROCEDURE INFORMATION

Side of Body (Check one): Right Left Bilateral

ICD9-CM Primary Diagnosis Code: ______________ CPT Code(s): ____________________

Procedure Description: ____

Return the completed form by

PHONE
(800) 541-2894

FAX
(877) 665-0383

MAIL
Qualis Health
PO Box 33400
10700 Meridian Ave. N, Suite 100
Seattle, Washington 98133-9075

Revised 6/22/2012