



SURGICAL PROCEDURE REQUEST FOR REVIEW FORM

Submitted by (all fields required)

Contact: Phone #: Fax #:

Patient Information (all fields required)

First Name: Last Name: WA Medicaid ID #: Date of Birth: Gender: Female Male

NOTE: Review is only performed by Qualis Health if the patient has Fee-For-Service Medicaid. Check eligibility thru the Provider One system prior to submitting requests. http://hrsa.dshs.wa.gov/Download/ProviderOne_Billing_and_Resource_Guide/Client_Eligibility_BSP_Coverage.pdf

Primary Surgeon Information (all fields required)

Provider Name: Provider Phone #: Provider Fax #: Provider Individual NPI ID #:

Facility Information (all fields required)

Facility Name (required): Facility Phone #: Facility Fax #: Facility NPI ID # (required):

Surgical Procedure Information

Date of Surgery: OR Pending Approval ICD9-CM Diagnosis Code (one is required): Primary Procedure CPT Code (required): Additional Procedure CPT Codes: Side of Body: Right Left Bilateral Spine Surgery Level(s):

Additional Information (Modifiers, assistant or co surgeon name/NPI)

Type of Request: Initial Request Re-Review of prior denial - reference number:

All requests must have clinical documentation submitted for review

Table with 2 columns: Internet (preferred) and Mail. Includes contact information and login URL.