Exhibit 11

QUALIS HEALTH

Concurrent Review Request Form

PLEASE VERIFY ELIGIBILITY BEFORE SUBMITTING

URAC ACCREDITED CASE MANAGEMENT HEALTH UTILIZATION MANAGEMENT INDEPENDENT REVIEW

Providers are required to submit review requests via the Qualis Health web-based review system, iEXCHANGE. Please see section 8 of this manual for additional information

Patient Information *(Please print or type)*

Patient Name		Admit Date
Gender Male ☐ Female ☐	Patient ID # or L&I #	Patient DOB
Subscriber Name *(If different from patient)*		ID #
FOR L&I ADMISSIONS ONLY:		
Description of Injury		Date of Injury

Facility and Attending Physician Information *(Please print or type)*

Facility Name	
Facility Reviewer Name	Phone #
Attending Physician Name	Phone #

Clinical Information *(Please print or type)*

Primary Diagnosis w/ ICD-9 Code	CPT Code(s)
Number of Days Requested	Date Range of request
Chart Notes Attached? ☐ Yes ☐ No	Number of Pages

Current Treatment Plan

Diagnostic Results	Lab Results

Discharge Plan or Other Issues

Mail medical record to Qualis Health
Qualis Health
PO Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133-0400
(800) 240-0437