



Pre-service Review Request FAX Form

DATE: _____

ATTN.: _____

FAX #: _____ **PHONE #:** _____

FROM: _____

FAX #: _____

NUMBER OF PAGES (INCLUDING COVER SHEET): _____

If there is problem with the receipt of this facsimile, please call. _____ Thank you.

RECIPIENT/PATIENT NAME: _____

RECIPIENT/PATIENT DATE OF BIRTH: _____

COMPLETE RECIPIENT ADDRESS: _____

MEDICAID NUMBER: _____

REQUESTED ADMIT DATE: _____ **DIAGNOSIS CODE(S)** _____

PROCEDURE DATE(S): _____

DAYS REQUESTED: _____ **PROCEDURE CODE(S)** _____

CONTINUED STAY REVIEW? Y () IF SO, REFERENCE # _____

NEW ADMIT? () TRANSFER ()

SETTING: **INPATIENT** **OUTPATIENT** **PHYSICIAN OFFICE** **OUT OF STATE**
 NON-URGENT **URGENT**

PHYSICIAN NAME: _____ **PHONE #** _____

FAX # _____

FACILITY: _____ **PHONE #** _____

FAX # _____

CLINICAL INFORMATION: _____

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Thank you.

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