QUALIS HEALTH

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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Phone: (800) 783-9207 **Alaska Review FAX (800) 826-3630**