



ADVANCED IMAGING REQUEST FOR REVIEW FORM

**Type of Review:** *(check one)*

- Pre-Service Request
- Retro Request

Submitted By: *(required)*

Contact: _____

Phone: _____

Patient Information: *(required)*

Name: _____ L&I Claim #: _____

Date of Birth: _____ Date of Injury: _____ Social Security #: _____

Ordering Provider Information: *(required)*

Provider Name: _____ L&I Provider ID#: _____

Provider Phone #: _____

Facility Information:

- Unknown *(to be determined)*

-OR- Facility Name: _____ L&I Facility ID#: _____

Facility Phone #: _____

Imaging: *(required)*Date of Imaging: *(check one)* To Be Scheduled Date: _____Diagnosis Code: *(one per request)* ICD9-CM: _____ Procedure Code: *(one per request)* CPT : _____Side of Body: *(check one)*
 Left Right Bilateral Body Part: _____*Please Note: Not all CPT codes require review. A separate questionnaire and form must be submitted for each body part.*

DO NOT SUBMIT WITHOUT A COMPLETED QUESTIONNAIRE

Please submit this information by one of the following methods:	
Internet (preferred) <i>This form is <u>not</u> necessary for IEXCHANGE®</i>	Log in at: http://www.onehealthport.com/services/Qualis_prere2.php
Fax	(877) 665-0383
Mail	Qualis Health Attention: Workers' Comp PO Box 33400 Seattle, WA 98133-0400