ADVANCED IMAGING
REQUEST FOR REVIEW FORM

Submitted by *(required)*

Contact: _____

Phone #: _____ Fax #: _____

Patient Information

Name *(required)*: _____

WA Medicaid ID # *(required)*: _____

Date of Birth: _____ Social Security #: _____

Ordering Provider Information *(required)*

Provider Name: _____

WA Medicaid NPI ID #: _____ Provider Fax #: _____

Facility Information

Imaging Facility Name *(required)*: _____

Facility Fax # *(required)*: _____ Facility Phone #: _____

WA Medicaid Facility NPI ID # *(required)*: _____

Imaging Information

Date of Imaging: ☐ Unknown or Date: _____

ICD9-CM Diagnosis Code *(required)*: _____

CPT Procedure Code *(required)*: _____

- only 1 per request
- not all codes require review

Side of Body: ☐ Right ☐ Left ☐ Bilateral ☐ N/A

Body part requested for imaging _____

- a separate questionnaire is required for each body part

DO NOT SUBMIT WITHOUT COMPLETED QUESTIONNAIRE

Please submit this information by one of the following methods:	
Internet *(preferred)* This form is ***not*** necessary for internet review requests.	Log in at: http://www.onehealthport.com/services/Qualis_prere2.php
Fax	(888) 213-7516
Mail	PO Box 33400 Seattle, WA 98133-0400

Qualis Health contact #: (888) 213-7513