ADVANCED IMAGING
REQUEST FOR REVIEW FORM

Submitted by *(all fields required)*

Contact: _____

Phone #: _____ Fax #: _____

Patient Information *(all fields required)*

First Name: _____ Last Name _____

WA Medicaid ID # *(9 digits ending in WA)*: _____

Date of Birth: _____ Gender: ☐ Female ☐ Male

NOTE: Review is only performed by Qualis Health if the patient has Fee-For-Service Medicaid. Check eligibility thru the Provider One system prior to submitting requests.
http://hrsa.dshs.wa.gov/Download/ProviderOne_Billing_and_Resource_Guide/Client_Eligibility_BSP_Coverage.pdf

Ordering Provider Information *(all fields required)*

Provider Name: _____

Provider Phone # _____ Provider Fax #: _____

Provider's Individual NPI ID #: _____

Facility Information *(all fields required)*

Imaging Facility Name *(required)*: _____

Facility Phone #: _____ Facility Fax #: _____

Facility NPI ID # *(required)*: _____

Imaging Information

Date of Imaging: ☐ Unknown or Date: _____

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

CPT Procedure Code *(required)*:
only 1 per request _____

Side of Body *(for joint imaging):* ☐ Right ☐ Left ☐ Bilateral ☐ N/A

Body part requested for imaging _____

- a separate request AND questionnaire is required for each body part

Type of Request: *(Please check one)*

☐ Initial Request – MUST SUBMIT WITH COMPLETED QUESTIONNAIRE

☐ Re-Review of prior denial – reference number: _____

****Must submit chart notes for review – *do not send questionnaire*

☐ Repeat Imaging – If imaging being requested has been performed within the last 3 months, submit chart notes which support the need for repeat imaging

Date of Previous Imaging: _____

Please submit this information by one of the following methods:	
Internet ***(preferred)*** Form ***not*** necessary for internet 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