



**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.

**CLIENT/PATIENT NAME:** \_\_\_\_\_

**CLIENT/PATIENT DATE OF BIRTH:** \_\_\_\_\_

**COMPLETE CLIENT ADDRESS:** \_\_\_\_\_

**MEDICAID NUMBER:** \_\_\_\_\_

**REQUESTED ADMIT DATE:** \_\_\_\_\_ **DIAGNOSIS CODE(S)** \_\_\_\_\_

**PROCEDURE DATE(S):** \_\_\_\_\_

**DAYS REQUESTED:** \_\_\_\_\_ **PROCEDURE CODE(S)** \_\_\_\_\_

**NEW ADMIT? ( ) TRANSFER ( )**

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

**PHYSICIAN NAME:** \_\_\_\_\_ **PHONE #** \_\_\_\_\_

**FAX #** \_\_\_\_\_

**FACILITY:** \_\_\_\_\_ **PHONE #** \_\_\_\_\_

**NPI#:** \_\_\_\_\_ **FAX #** \_\_\_\_\_

**CLINICAL INFORMATION:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Thank you.

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