



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 # _____

PHYSICIAN NPI#: _____ FAX # _____

FACILITY: _____ PHONE # _____

FACILITY NPI#: _____ FAX # _____

CLINICAL INFORMATION: _____

This message is intended for the use of the individual entity to which it is transmitted and may contain information that is privileged, confidential and exempt from disclosure under applicable laws. If the reader of this communication is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by phone and return the original communication to us at the address below via U.S. Postal Service. We will reimburse you for the mailing costs.

Thank you.

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