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Pre–service Review Request Fax Form

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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:_____

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670 East Riverpark Lane, Suite 170 Boise, ID 83706
Phone: (866) 538-9510 **Idaho Review FAX (866)** 539-0365