Exhibit 15

Retrospective Review Request Form

Providers are required to submit review requests via the Comagine Health web-based review system, iEXCHANGE. Please see section 8 of this manual for additional information

PATIENT INFORMATION		Request Date:
Patient Name	Patient Date of Birth	Insurance ID #

Insurance Information: ☐ AK Medicaid ☐ ID Medicaid ☐ WA Labor & Industries ☐ Private

FACILITY INFORMATION			
Facility	Admit Date	Discharge Date	Physician
UR Contact Person	UR Phone #	Fax #	

Request Reason (PLEASE CHECK ALL THAT APPLY):

☐ Exceeds LOS ☐ Pre–Service Review Late ☐ Other _____

☐ Medicaid Patient (Eligible post admit date) eligible date _____

☐ Medicaid Eligible (Eligible before admit date) eligible date _____

☐ Concurrent Review Late Previous authorization # _____

For lengths of stay **less than 15 days, please submit the following information:**

☐ UB 04 ☐ DC Summary

☐ H & P ☐ Operative Report (if applicable)

For lengths of stay **15 days or greater** & ID Medicaid psych diagnosis for patients under age 21,
PLEASE SEND ENTIRE MEDICAL RECORD

Additional Information needed for

- Rehabilitation: Weekly Team Meeting Notes, Functional Status, Goals
- Adult Psychiatric/Chemical Dependency: MD and Multi–disciplinary Progress Notes, Medication Administration Record

ADDITIONAL INFORMATION MAY BE REQUESTED

Mail medical record to Comagine Health
Comagine Health
PO Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133-0400

For Internal Use Only – Calls Made for Additional Information

☐ _____ ☐ _____ ☐ _____
date date date