Comagine Health

State of Alaska Behavioral Health Inpatient Psychiatric Review

☐ **Retrospective Review Request**
☐ **Late Submission Request**

CLIENT INFORMATION		**Request Date:**
Client Name	Client Date of Birth	Insurance ID #

Insurance Information: ☐ AK Medicaid

FACILITY INFORMATION

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

Request Reason (PLEASE CHECK ALL THAT APPLY):

☐ **Delayed Eligibility** _____

Date facility was notified of eligibility _____

☐ Late Submission (post 30 days) _____

☐ Retrospective (client has discharged and no initial review has been submitted) _____

Please write a statement below showing reasons for the late submission request.

Additional Information may be requested.

NOTE:

Please submit retro reviews via Comagine Health Provider Portal (preferred method).

Fax completed form to Comagine Health
AK Medicaid Patients: 877-200-9047

For Internal Use Only – Calls Made for Additional Information

☐ _____ **date** ☐ _____ **date** ☐ _____ **date**