ADVANCED IMAGING REQUEST FOR REVIEW FORM

Please fax form and supporting documentation to 877-665-0383

PLEASE COMPLETE ALL FIELDS.

Submitted by:

Contact: _____

Phone #: _____ Ext/Option #: _____ Fax #: _____

Worker Information:

Name: _____ L+I Claim #: _____

Date of Birth: _____ Date of Injury: _____

Ordering Provider Information:

Provider Name: _____ L&I Provider ID #: _____

Provider Phone #: _____ Provider Fax #: _____

Facility Information:

□ Unknown *(to be determined)*

Facility Name: _____

Facility Phone #: _____ L&I Facility ID #: _____

Imaging:

Date: □ To be scheduled □ Date planned: _____ □ Already done (Date completed): _____

Diagnosis Code *(**one is required**)* - ICD9-CM: _____

Procedure Code *(**only one allowed per request**)* - CPT: _____

Please Note: *Not all CPT codes require review.* *http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/default.asp*

Side of Body for joint imaging: *(check one)*

□ Left □ Right □ Bilateral Body Part: _____

Please Note: *Not all CPT codes require review. A separate questionnaire and form must be submitted for test requested unless bilateral imaging is requested.*

Type of Request:

(Please check one)

□ **Initial Request** – MUST SUBMIT WITH COMPLETED QUESTIONNAIRE

□ **Re-Review of prior denial** – Reference number: **250 _ _ _ _ _ _ _**
Must submit chart notes for review. DO NOT SEND QUESTIONNAIRE

Qualis Health Use Only - Reference #:

Qualis Health provides only recommendations on medical necessity. L&I makes the final determination regarding authorization.

For program information, call Qualis Health Workers' Compensation at (800) 541-2894 or visit our website:
http://www.qualishealth.org/healthcare-professionals/washington-labor-industries

Internet ***(preferred)***	**Login at:**
This form is ***not*** necessary for iEXCHANGE®.	http://www.onehealthport.com/services/Qualis.php