SURGICAL 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:

Facility Name: _____

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

Surgical Information: □ IP □ OP **(Group A Provider: Please use Group A form)**

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

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

Requested Length of Stay if Inpatient: _____

Primary Procedure CPT Code *(**required**)*: _____

Additional Procedure CPT Codes: _____

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

Procedure Description: _____

_____

Complete the following for extremity, joint and spine surgery only:

□ Left □ Right □ Bilateral Spinal Levels: _____

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