SPINAL INJECTION REQUEST FOR REVIEW FORM

Please fax form and supporting documentation to 888-213-7516

PLEASE COMPLETE ALL FIELDS.

Submitted by:

Contact: _____

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

Patient Information: *(all fields required)*

First Name: _____ Last Name: _____

WA Medicaid ID #: __ __ __ __ __ __ __ __ __ Date of Birth: _____ ☐ Female ☐ Male

NOTE: Review is only performed by Qualis Health if the patient has Fee-For-Service Medicaid.
Check eligibility thru the Provider One system prior to submitting requests:
http://www.hca.wa.gov/medicaid/provider/Documents/provideroneguide/client_eligibility_bsp_coverage.pdf

Ordering Provider Information:

Provider Name: _____

Provider Phone #: _____ Provider Fax #: _____

Individual NPI #: _____ ***Billing NPI #*** (if different): _____

Facility Information:

Facility Name: _____ NPI #: _____

Facility Phone #: _____ Facility Fax #: _____

Injection Information: Date:

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

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

Procedure(s) CPT: _____

Please Note: Not all CPT codes require review. http://www.hca.wa.gov/medicaid/rbrvs/Pages/index.aspx

Site to be injected (***check only one***): ☐ Left ☐ Right ☐ Bilateral ☐ Interlaminar ☐ Caudal

Spinal Nerves/Levels to be injected: _____

Please see guidelines for limitations, number of levels per side of body allowed per date of service.

Type of Request: *(Please check one)*

☐ **Initial Injection** - MUST SUBMIT WITH COMPLETED QUESTIONNAIRE

☐ **Second request** for injection at level previously injected - MUST SUBMIT WITH COMPLETED QUESTIONNAIRE

☐ **Third request** for injection at level previously injected - MUST SUBMIT WITH COMPLETED QUESTIONNAIRE. Chart notes may be requested.

☐ **Full review of prior denial** - Must submit chart notes. DO NOT SEND QUESTIONNAIRE.
Reference number of prior denial: 913 __ __ __ __ __ __

NOTE: If chart notes are required, submit the following: initial consult, follow-up visit notes, physical exam; imaging reports, and documentation of conservative care.

Qualis Health Use Only - Reference #:

Qualis Health provides only recommendations on medical necessity. Health Care Authority makes the final determination regarding authorization.

For program information, call Qualis Health Washington Medicaid at (888) 213-7513 or visit our website:
http://www.qualishealth.org/healthcare-professionals/washington-medicaid

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