SURGICAL PROCEDURE
REQUEST FOR REVIEW FORM

Submitted by *(all fields required)*

Contact: _____

Phone #: _____ Fax #: _____

Patient Information *(all fields required)*

First Name: _____ Last Name _____

WA Medicaid ID # *(9 digits ending in WA)*: _____

Date of Birth: _____ Gender: ☐ 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://hrsa.dshs.wa.gov/Download/ProviderOne_Billing_and_Resource_Guide/Client_Eligibility_BSP_Coverage.pdf

Primary Surgeon Information *(all fields required)*

Provider Name: _____

Provider Phone # _____ Provider Fax #: _____

Provider Individual NPI ID #: _____

Facility Information *(all fields required)*

Facility Name *(required)*: _____

Facility Phone #: _____ Facility Fax #: _____

Facility NPI ID # *(required)*: _____

Surgical Procedure Information

Date of Surgery: _____ **OR** ☐ Pending Approval

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

Primary Procedure CPT Code *(required)*: _____

Additional Procedure CPT Codes: _____

Side of Body: ☐ **Right** ☐ **Left** ☐ **Bilateral** Spine Surgery Level(s): _____

Additional Information (Modifiers, assistant or co surgeon name/NPI) _____

Type of Request: *(Please check one)*
☐ Initial Request
☐ Re-Review of prior denial – reference number: _____

All requests must have clinical documentation submitted for review

Please submit this information by one of the following methods:	
Internet ***(preferred)*** Form ***not*** necessary for internet requests.	Log in at: http://www.onehealthport.com/services/Qualis_prere2.php
Fax (888) 213-7516	**Mail** PO Box 33400 Seattle, WA 98133-0400

Qualis Health contact #: (888) 213-7513