Medical Necessity Review Form

Fax to: 319-398-3292

Please fill out all sections of this form in order for your request to be processed in a timely manner. If you have any questions please contact us.

*****Allow 30 days for this review*****

Date: ______________ **Date of Service:** ______________

Contact Name ______________________ **Phone #:** ________________ **Fax #** ________________

Requesting Facility Name & Address: ____

Member Name: __________________________ **Patient Name:** ____________________________

ID/SSN: ________________________________ **Patient DOB:** _____________________________

Group Name: ______________________________________ **Group Number** ________________

Referral for: Please carefully select one of the choices below.

☐ **Medical Necessity Review of Procedure – We will review.**
Procedure being Requested (CPT codes and descriptions): ______________________________
____

Diagnosis Code(s): ____

Proposed Treatment Plan (Please be as specific as possible, use another page if necessary):
____
____
____

* You **must** attach any documentation necessary for reviewing medical necessity.
Not including needed documentation will cause unnecessary delays in reviews.
***Services that have already taken place and denied as not medically necessary will remain denied.*

☐ **Other** – ____
____
____

**Include any supporting documentation needed.

Be sure to attach: A separate paper that details the services needing approval or detailed reason for your appeal. Include the required documents necessary for the review type requested. Missing information only delays the processing time of this request.

INTERNAL OFFICE USE ONLY:

Referred by: ______________________ Eff. Date: ______________ Plan Language Pages(s): ______

Examiner Comments: ____
____

Notes entered into the system by Examiner: ☐ Yes ☐ No

Reviewed by: ________________ Date: __________________

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