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|   | **https://insight.ifmc.org/Logos/telligen_no_tag_color.jpg** |

**Retro-Eligibility Review Request Form**

**PLEASE VERIFY ELIGIBILITY BEFORE SUBMITTING**

**Patient Information** *(please print or type)*

|  |
| --- |
| **Date Review Requested:**  |
| **Facility Name:**  | **Facility MA #:**  |
| **Patient’s Name:**  | **Patient’s MA #:**  |
| **Admission Date:**  | **Discharge Date:**  |
| **# of Acute Days Requested:**  | **# of Administrative Days Requested:**  | **1288 Attached** **[ ]**  |
| **Primary Diagnosis:**  | **CPT Code:**  |
| **Secondary Diagnoses:**  | **CPT Code:**  |
|  |  |
|  |  |
| **Procedure Codes:**  |
| **DRG:** | **Discharge Status:** |

**Submitter Information** *(please print or type)*

|  |  |
| --- | --- |
| **Name:**  | **Phone Number:**  |
| **Fax Number:**  | **Email Address:**  |

**Review Type:** **[ ]  Retrospective Review** **[ ]  Reconsideration**

**Was Eligibility Determined Retrospectively?** **[ ]  Yes** **[ ]  No**

**If you only receive part of this transmission, or if transmission is illegible, please call the facsimile operator at**

**443-561-3320.**

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