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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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