Date of Request:____/____/______

RETRO REVIEW FORM

Patient Name:______________________________ **Member ID #** ____________________________

Patient DOB:_____/____/______Patient Phone: (____)_____-_______Different Last Name: ____________________

Ordering Physician:______________________________ Address: ______________________________

City:____________________State:_____Zip ________ Phone: (___)_____-_______ Fax: (___)_____-_________

Contact Person: ________________ **Fax:** ( )____-_____ Contact Phone: (___)_____-_______ Ext: _

Physician Tax ID#:______________________ NPI#: _____________________________________

FACILITY FOR SERVICE: CLAIM #______________________ Fax: ( ) -

Name:______________________________________ Phone: ( ) - ________

Address, City, State: ____

Facility Tax ID:___________________________Facility NPI#: ________________________________

Date of Service:_____/____/______ PLEASE CHECK CORRECT SERVICE BELOW

SERVICE TYPE: Physical Therapy ____________ Occupational Therapy ____________ Speech Therapy __________ Brace _______

Chiro ________ Genetic Testing __________ OP Surgery _________ Diag Testing _______________ Sleep Study _________

Radiology __________ DME _______ Prosthetics/Orthotics ____CPAP ___ OTHER ____

Admission date / / DC date / / LOS

Diagnosis	ICD10

PLEASE PROVIDE ALL CLINICAL DOCUMENTATION FOR PROCESSING.

CPT CODES	Description	Quantity Requested	Date Range Start and End

FAX TO: CLAIMS@CUSTOMDESIGNBENEFITS.COM OR FAX TO 513-389-2998

This authorization is not a guarantee of payment. Plan benefits are based on the patient's eligibility at the time of service. For questions on eligibility and benefits call 513-598-2929/800-598-2929

MM Form 2018