**Retrospective Review Cover Sheet**

**Retrospective reviews must be received in writing and can be requested via fax or mail.**

**Note: Please do not submit a Service Authorization form. Only use this cover sheet for Retrospective Review Requests.**

 Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Participant ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Participant DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Health Plan/Group: STATE OF ALASKA

 Provider Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Provider/Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Provider/Facility TAX ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Rendering Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dates of Service for retro request **ONLY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Do not include future dates. If requesting more than one procedure code enter the date range with the

 number of units and days for each)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Diagnosis Code(s)  | Procedure Code | Modifier | U=Units, D=Days, S=Sessions | # Requested |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
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|  |  |  |  |  |

 Reason prior authorization was not obtained: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please include: (If documents are not submitted, a review cannot be completed)**

**£ Biopsychosocial Assessment (Include any other assessments applicable)**

**£ Treatment plan for dates of service requested**

**£ Medical necessity tool (i.e.: CALOCUS-CASII, LOCUS, ASAM, ECSII)**

**Additional documents may be requested as needed**