**Retrospective Review Cover Sheet**

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

**Note: Do not submit a Service Authorization form.**

**\*Only use this cover sheet for Retrospective Review Requests Only**

Participant Name:

Participant ID:

Participant DOB:

Health Plan/Group: STATE OF ALASKA

Provider/Facility Name:

Provider/Facility NPI:

Dates of Service for retro request **ONLY** (Do not include future dates):

Number of Days/Sessions Requested:

Reason prior authorization was not obtained:

**Please include:**

* **Treatment plan**
* **Any other supporting documentation for this request**

**If documents are not submitted, a review cannot be completed.**