Print Form

PEER REVIEW REQUEST

PRO PEER RESOURCES, INC.

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DATE: _____ If submitted by FAX, total # of pages _____

CLIENT: _____ Acct. Number: _____

Address: _____

City/State/Zip _____

PHONE: _____ FAX: _____

CONTACT PERSON: _____ EXT _____ /email _____

Plan/Group/Administrator _____

☐ THIS CASE IS ERISA Has ProPeer Reviewed this case before? ☐ No ☐ Yes = C/N _____

PATIENT/INSURED'S INFORMATION	REVIEW REQUEST:
PATIENT _____ INSURED _____ ID# _____ *JURISDICTIONAL STATE:*_____ PROVIDER (FACILITY) BEING REVIEWED: _____ SPECIALTY: _____ DATE(S) OF SERVICE UNDER REVIEW: _____	REVIEW REQUIREMENTS ☐ **STANDARD** (Post Service/Standard) ☐ **72 HOUR** (Pre-Service/Expedited) ☐ **24 HOUR/STAT** (Concurrent/Urgent Care) Report Needed By: *(Date/Time)* _____ REVIEWER REQUIREMENTS ☐ "Same State Licensed" Reviewer Required ☐ Reviewer's Signature Required *APPEAL CLASSIFICATION* ☐ This case is an Appeal of a prior denial ☐ 1st Level Appeal ☐ 2nd Level Appeal

REVIEW REQUEST

SPECIFIC QUESTIONS FOR REVIEWER: **POLICY/PLAN LANGUAGE PROVIDED** ☐ YES ☐ NO