Med Review Request

Form to be used for Med Review requests only. Clinical information must be submitted with this completed form.

Referral date: _____ **# pages sent:** _____

Med Review requestor: _____

TPA/ Client: _____

Fax number: _____ **Phone number:** _____ **Email:** _____

TPA mailing address: _____

Group name: _____

Patient name: _____ **DOB:** _____

Member name: _____ **Member ID:** _____

Case number, if applicable: _____ **Date of service (DOS):** _____

Provider name(s): _____

Review services/ requested:

Check if request is urgent ☐ **Medical necessity** ☐ **Disability review** ☐

Claims review ☐ **UCR (Usual & Customary)** ☐ **Dental review** ☐

Other (please specify): _____

Issue to be resolved (please specify):

ICD-10 code(s)

CPT/HCPCS code(s)

Digital photos/ x-rays ☐

Please send Fax or Secure Email request to AHH Med Review Department
Fax: 866-537-5449
Email: ahh_medreview@ahhinc.com

PLEASE NOTE:

- Clinical information should be submitted with this completed form.
- Requests sent without documentation may delay review time.
- Completion of Standard Med Review may take up to 10 business days.
- Rush or stat cases will be taken on individual basis, please allow 2-3 business days for completion.
- Completion of Specialty Process Cases (e.g., Oncology) may require up to 30 calendar days.