

Fax/Written Request Basic Information

PROVIDER INFORMATION		
NAME		PROVIDER NPI
TELEPHONE NUMBER	FAX NUMBER	
CLIENT INFORMATION		
NAME		PROVIDER ONE CLIENT ID
SERVICE REQUEST INFORMATION		
Description of service being requested		
PROCEDURE CODE	NUMBER OF UNITS REQUESTED	NUMBER OF UNITS USED THIS YEAR
MEDICAL INFORMATION		
DATES OF INJURY OR ILLNESS		
DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION	
PLACE OF SERVICE		
How will approving this request change the course of treatment?		
Goal of treatment?		
What is the clinical justification for this request (if not addressed above)?		

REQUIRED INFORMATION:

Please send or fax charts, justification, and any necessary additional documentation with your request to:
 Health Care Authority
 Provider Request/Client Notification Unit
 PO Box 45535, Olympia WA 98504-5535
 Phone: 1-800-562-3022
 Fax: 1-866-668-1214

A typed and completed General Authorization for Information form (HCA 13-835) must be attached to your request.