157 S. Broad Street ♦ Suite 400
Lansdale ♦ PA ♦ 19446
215.855.IMED ♦ Fax: 215.855.5318
www.imedecs.com

CASE REVIEW REQUEST FORM

Thank you for choosing IMEDECS as your source for quality, comprehensive medical case review services.
Please complete this form and fax it back to us at (215) 855-5318.

ORDER DATE: ________________ **CLIENT TRACKING# / IDENTIFIER: ______________**

STEP 1: Select Service

External Review ☐
Internal review: Level I ☐ Internal review: Level II ☐
Medical Coverage Policy Evaluation ☐
Disability Review ☐
Coding Review ☐

Check the following if relevant:

STATE MANDATED REVIEW list State here ______
ERISA case ☐
PEER to PEER contact, if required ☐

STEP 2: Select Case Review Methodology (select only one methodology):

	Review Methodology	Documentation for review may include:
☐	Experimental/ Investigational	Database searches, journal articles/peer-reviewed literature, manufacturer's materials, relevant medical records and plan language (where allowed), correspondence and reason for denial
☐	Medical Necessity	Plan language and definitions, plan or commercial review/coverage criteria, clinical practice or pharmacy guidelines, relevant medical records, correspondence and reason for denial.
☐	Opinion only	Plan language, denial correspondence, relevant medical records. (not evidence-based)
☐	Benefit coverage	Certificate of coverage/exclusion language, relevant medical records, correspondence and reason for denial.

STEP 3: Required Information (please complete all pertinent sections):

1. Patient's Name:	Age:	Sex:
If patient should receive report *please include Patient's Address:*		
Diagnosis(es):		
Procedures(s):		
Treating Facility:		
Treating Provider:		
Provider Specialty:		
If Provider should receive report *please include Provider's Address:*		
Provider's Phone:	*Provider's Fax:*	

STEP 4: Questions to be Addressed (Sample Questions are available on website):

____

____

____

____

STEP 5: Select Panel Size: Single Physician ☐ Two Physicians ☐ Three Physicians ☐

STEP 6: Select Time Frame Required: **DESIRED DATE of Completion __________________**

IMEDECS Timeframe *(calendar days)*

Standard (6+ days): ☐
Expedited (3-5 days): ☐
Emergency (1-2 days): ☐ *(not available for evidence-based reviews)*

OR

State Mandated Timeframe *(calendar days)*

Standard: ☐ ______ **days**
Expedited: ☐ ______ **days**

ERISA Mandated Timeframe

Standard: ☐
Expedited: ☐

This fax may contain information which is proprietary, confidential, and the property of IMEDECS. Please direct this document only to the addressee named above. If the document has been received by an installation other than that named above, please contact us and we will arrange for the return of this document at no cost to you.

157 S. Broad Street ♦ Suite 400
Lansdale ♦ PA ♦ 19446
215.855.IMED ♦ Fax: 215.855.5318
www.imedecs.com

STEP 7: Contact Information

PRIMARY CONTACT:		BILLING CONTACT (if different):	
Name:		Name:	
Title:		Title:	
Company:		Company:	
Address:		Address:	
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:
E-mail:		E-mail:	

TERMS OF AGREEMENT:

All Review Services provided by **IMEDECS,** represent the opinion of physicians(s) and/or other clinical specialist(s) regarding a medical treatment/plan of care or care delivered for a specific patient or patients with a specific clinical condition(s)/diagnosis(es), health insurance coverage policy, or clinical practice/review guidelines. **IMEDECS** utilizes independent physicians and/or other clinicians (contractors) that have been credentialed according to URAC and other relevant state and federal government standards. **IMEDECS** contractors' education, specialty training and credentials, experience and professional reputation qualify them as appropriate specialists to review the case(s) assigned to them by **IMEDECS**. In arriving at opinions regarding the medical appropriateness, medical necessity, and/or experimental/investigational status of the questioned treatment/plan of care, **IMEDECS** physician/clinician contractors review medical records and other documents submitted to **IMEDECS** by the health care facility, health plan, patient's physician(s) and/or patient/enrollee. Physician/clinician contractors also consider published scientific medical evidence and other relevant information such as that available through federal government agencies, institutes, and professional associations. The opinions of contractors reflected in case review report conclusions are provided in good faith. **IMEDECS** assumes no liability for the opinions of its experts. The health plan, organization, or other party authorizing this review agrees to hold **IMEDECS** and its contractors harmless for any and all claims that may arise as a result of this review where such liability results from negligent acts or omissions of Purchaser. Any decisions regarding privileging, credentialing or other actions to be taken regarding a physician(s), network of physicians, or health care facility are solely within the discretion of the health plan, organization, or other party authorizing this review.

For the purposes of this Review, the parties intend that the activities of **IMEDECS**, its staff, contractors and expert reviewers shall be protected by the state peer review protection act applicable in the jurisdiction in which the review originates, and by the Federal Health Care Quality Improvement Act.

By transmitting this Review Request Form, the referring entity represents that it has complied with all applicable laws and regulations governing the performance of independent medical case reviews, and that **IMEDECS** will rely on such representation by the referring entity.

Purchaser, through its undersigned, authorized representative, authorizes **IMEDECS** to proceed with the case review as indicated above. Purchaser agrees to remit the agreed upon fixed fee, or amount to be determined and based on consulting time and direct expenses. Payment terms are net 30 days, with interest applied after 30 days at 1 l/2% per month. If the purchaser cancels the review after authorization to proceed has been given, purchaser agrees to remit the expenses incurred by **IMEDECS** up through the time of cancellation on a time and material basis. Purchaser has read, understands and accepts the terms of agreement.

______________________________________ _______________________
Signature of Authorized Representative **Date**

____
Printed Name and Title of Authorized Representative

____
Purchaser (Corporation/Organization/Agency)

This fax may contain information which is proprietary, confidential, and the property of IMEDECS. Please direct this document only to the addressee named above. If the document has been received by an installation other than that named above, please contact us and we will arrange for the return of this document at no cost to you.