

Schwabacher

Health Insurance Consulting, Inc.

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HOTLINE CLAIM REVIEW SUBMISSION

Number of Pages Including This Cover Page:

Identification

Date Submitted:

Employee Name:

Claimant Name:

ID#

Group Name:

Dates of Service in Question:

Type of Review (check all applicable)

R&C. R&C data and percentile used: (Please provide your data if you would like us to utilize your data for the analysis.)

Unbundling

Medical Necessity

Experimental and/or Investigational

Over utilization

Cosmetic

Pre-existing condition. Hire date: ___/___/___ Coverage date: ___/___/___

Eligibility. Hire date: ___/___/___ Coverage date: ___/___/___

Plan Exclusion/Limitation. Please specify:

Other:

Please submit applicable Plan Language (including, but not limited to: definitions (medical necessity, at a minimum), rebundling, covered expenses, Plan exclusions and limitations.

Comments

Review requested by:

Name of Company/Address:

Email:

Phone#

Fax#

Mail to: Schwabacher Health Insurance Consulting, Inc

6802 North Table Mountain Road

Tucson, AZ 85718

Email: info@shicinc.com