

## REQUEST FOR RETROSPECTIVE PACER REVIEW

The Pacer Program will not process your request for review unless all information is provided. Forwarding the medical record is not encouraged. To expedite this process use of the Retrospective Review form is recommended. [Please note: if the patient's Medicaid was made retroactive to the time of service, no pacer number (Retrospective Review) is required.]

**PLEASE PRINT OR TYPE:**

Primary Insurance:  Fee for Service (FFS)

Has case been billed and rejected:  Yes  No

Secondary Insurance:  Yes  No

Beneficiary ID#: \_\_\_\_\_

Facility NPI #: \_\_\_\_\_

First Name: \_\_\_\_\_

Attending's Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Attending's Specialty: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

Sex:  M  F

Type of Admission:  Elective  Urgent/Emergent  Rehabilitation

Type of Review:  Admission  ReAdmission  Transfer  30-Day Rehabilitation  60-Day Rehabilitation

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**FIRST:**

Admitting Facility: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Diagnosis Description: \_\_\_\_\_

Codes for Procedures done within 24 hours of admission (**CPT/HCPCS**): \_\_\_\_\_

Narrative of Procedure: \_\_\_\_\_

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**SECOND:**

Readmission/Transfer Facility: \_\_\_\_\_

Readmit/Transfer Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_/

Diagnosis Description: \_\_\_\_\_

Codes for Elective Procedures done within 24 hours of readmit/transfer (**CPT/HCPCS**): \_\_\_\_\_

Narrative of Procedure (If applicable): \_\_\_\_\_

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**RETROSPECTIVE REVIEWS:**

Please provide a DETAILED DESCRIPTION (i.e. chief complaint, history, vital signs, test results, treatments, and interventions including medications-route and frequency).

**READMISSIONS:**

IN ADDITION TO THE ABOVE INFORMATION AT THE TIME OF READMISSION, include the patient's condition within 24 hours prior to discharge from first admission. (Specify condition at discharge including any UNRESOLVED SYMPTOMS, vital signs, test results and medication changes).

**TRANSFERS:**

IN ADDITION TO THE ABOVE INFORMATION AT THE TIME OF TRANSFER, include the REASON FOR TRANSFER. What service and/or treatment were available at the receiving facility that WAS NOT AVAILABLE at the transferring facility?

