Evry Healthcare Inc.
URA License # 2447557
PO Box 571208
Dallas, TX 75357

Retrospective Review Form

What is a retrospective review?

- A retrospective review is the process of determining coverage after treatment has been given.

When is retrospective review available?

- Retrospective review is available to a provider when all of the following criteria is met:
    - Confirming member eligibility and the availability of benefits.
    - The service has not been submitted for payment or processing.
- AND one of the following:
    - If the health plan authorized an initial inpatient request, a subsequent request will be accepted for review within 3 business days of the last approved day.
    - An additional service was identified as necessary when the original authorized service was performed. Requests for this additional service will be accepted within 5 business days of the performed service.

Retrospective review is not available for:

- Elective ambulatory or inpatient services on the preauthorization list for which preauthorization did not occur before providing the service.
- Services requiring notification within 3 business days that did not meet notification requirements (notification of inpatient admissions is required within 3 business days of admission date).
- Services not included on the preauthorization list.
- Services that do not require preauthorization under the terms of a member's plan.

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Evry Health Retrospective Review Form		
Issuer Name: Evry Health	Phone: 1-855-579-3879	Fax: 1-325-603-0541
Today's Date:		

Patient Information

Name:		Phone:		DOB:	
Subscriber Name:		Member ID:		Group:	

Ordering Provider or Facility

Name:		NPI:	
Phone:		Fax:	
Contact Name:		Phone:	

Servicing Provider or Facility

Name:		NPI:	
Phone:		Fax:	

Services Provided

Service or Procedure	Code	Date Performed	Diagnosis Description	ICD 10 Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Other:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions: Duration: Frequency: Other:

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits: Duration: Frequency: Other:

Please submit this form along with pertinent clinicals via fax to (325) 603-0541