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|  | **https://insight.ifmc.org/Logos/telligen_no_tag_color.jpg** |

**Retro-Eligibility Review Decision**

**Review Type:**  **Retrospective Review**  **Reconsideration**

**Review Information**

|  |  |
| --- | --- |
| **Facility Name:** | **Facility MA #:** |
| **Submitter Name:** | **Submitter Fax #:** |
| **Patient’s Name:** | **Patient’s MA #:** |
| **Admission Date:** | **Discharge Date:** |

**Review Decision**

|  |  |
| --- | --- |
| **Date Review Completed:** | |
| **Acute Date(s) of Service Approved:** | **Acute Date(s) of Service Denied:** |
| **Admin Date(s) of Service Approved:** | **Admin Date(s) of Service Denied:** |
| **Authorization/UB04 #:** | |

**Denial Letter Attached:  Yes  No**

**\*PLEASE NOTE: This case must be billed to Maryland Medicaid on paper. Please attach a copy of this decision sheet to the UB04 to avoid having the claim deny for timely filing.**

**If you only receive part of this transmission, or if transmission is illegible, please call the facsimile operator at**

**443-561-3320.**

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