



*Please allow 7-10 business days for review and response.
Responses are mailed and/or faxed if a fax number is provided.*

TYSON COURTESY REVIEW FORM			
DATE REQUEST SUBMITTED:			
SECTION 1 - REQUESTER INFORMATION			
Doctor/Facility Name:		Tax ID or NPI#:	
Network Status:			
Address:		Suite/Building:	
City:	State:	ZIP Code:	
Phone #:	Fax #:	Contact Person:	
SECTION 2 - PATIENT INFORMATION			
Patient Name:		ID #:(include Alpha Prefix)	
Address:		Apt #/Building:	DOB:
City:	State:	ZIP Code:	
Policy Holders Name:			
<i>Please Note: Sections 3-5 are for the performing/rendering providers' information.</i>			
SECTION 3 – RENDERING (NON-FACILITY) PROVIDER			
Provider Name		Tax ID or NPI#:	
Provider Specialty:			
Address:		Suite/Building:	
City:	State:	ZIP Code:	
Phone #:	Fax #:		
SECTION 4 – RENDERING FACILITY (IF APPLICABLE)			
Name of Facility:			
Address:		Suite/Building	
City:	State:	Zip Code:	
Phone #:	Fax #:		
SECTION 5 – SERVICE INFORMATION			
Scheduled Service Date:		Repeat Service (Y or N)	
CPT 4 Codes or HCPC Codes:			
Diagnosis Codes (ICD 10)			
If DME – indicate expected duration:			
Does the patient need additional visits or days for Occupational Therapy, Physical Therapy, Speech Therapy, Skilled Nursing Facility, Long-term Acute Care or Hospice? (Y or N)			
Please Attach Medical Records, Treatment Plan, and any other Supporting Documentation.			

*****NOTE*** A Courtesy Review will only be considered when complete medical records and a treatment plan or letter of medical necessity are submitted with this request. Please submit any supporting documentation that would be of assistance for this request.**