Prior Authorization Request Form
Fax to 800-316-0021

For questions about using the portal and UR/Prior Authorizations, please contact eQHealth Solutions at: **888-498-0939**

Contact Information

Contact Name	Phone	Fax	Date

General Information

Severity: ☐ Standard ☐ Urgent ☐ Emergent (Head in Bed)

Clinical Reason for Urgency:

Review Type: *Check all that apply*

☐ IPR/SNF (Same Day Transfer) ☐ Inpatient ☐ Initial ☐ Concurrent
☐ Transplant ☐ Outpatient ☐ Retrospective ☐ Future Admit

Patient Information

Name	DOB	

Subscriber Name (If Different)	Member ID	Sex	Address

Provider Information **IF Servicing is the same as Requesting write SAME in Servicing Information area**

Requesting Provider/Facility		Servicing Provider/Facility (If Applicable)	
Name		Name	
**NPI (Required)	**Tax ID (Required)	**NPI (Required)	**Tax ID (Required)
Phone	Fax	Phone	Fax
Address (Required for Mailing Denial Letter)		Address (Required for Mailing Denial Letter)	

Procedure Information

Planned Service/DME/Admission	CPT Code	Date of Service/ Admit	End Date/ Discharge (If Needed)	Main Diagnosis	ICD 10 Code

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Additional Clinical Explanation

***Please attach clinical documentation to faxes such as signs, symptoms, history, diagnostic test results, consultant recommendations (if applicable), and plan of treatment. Requests *cannot* be processed without this documentation. ** Comments:**

Severity Clarification:
**** Emergent:** Direct Admission; the member is currently in the hospital; "head in the bed" at the time of request

Additional information and instructions:
Contact information for the person requesting the authorization. This is the person that will be called with questions. If approved the form will be faxed back to this fax number. If denied, the denial letter will be faxed to this number and mailed to the "requesting physician".

Disclaimer Statement
eQHealth Solutions' certification determination does not guarantee payment for services. Eligibility for and payment of services are subject to all terms, conditions and limitations of the Summary Plan Description.

Requesting Provider Attestation Statement
I hereby attest that, as a healthcare services provider or provider's representative, an order for the above medical services has been received for the identified member. In addition, I attest that the treatment plan has been approved by the prescribing (ordering) physician.

Printed Name: _____ *Signature:*_____ *Date:*____ / ____ / _____

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