Hospital Contact Form

All information must be completed for processing.

Send completed form to:
eQHealth Solutions
Attention: Provider Education and Outreach
Fax: (630) 317-5101
Notice: It is important to notify eQHealth Solutions immediately when contacts change.

Hospital 12 Digit Medicaid Number

Provider Name

Hospital Address

City State Zip

Mailing Address (Add if different)

Street Address

City State Zip

ONLY FILL IN THE CONTACTS YOU WANT TO UPDATE

Position/Contact Type	Full Name	Prof. Suffix	Exact Title	Phone	Fax	Email
Administrator/CEO						
CFO						
Medical Director						
Hospital-assigned eQHealth Liaison						
Hospital-assigned Quality Contact						
Hospital-assigned Web Administrator						
Hospital-assigned 2nd Web Administrator						

Hospital CEO or CFO Signature(must be signed for eQHealth Liaison change)

eQHealth Liaison Signature(required for Web Administrator or Quality change)

Date:

Sign the appropriate field to the left and then click the button to the right to email your form directly to eQHeath Solutions' Provider Education

Email