**FSP Reconsideration Request Form**

**YOUTH’S INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Recipient ID#: |  | | | Sex: |  |  | Age: |  | DOB: | / / | | |
| (RIN) |  |  |  |  |  |  |  |  |  |  |  |  |
| Youth’s Name: |  | | | | |  | Review ID: | | |  | | |
|  | (First) | (MI) | (Last) |  |  |  |  |  |  |  |  |  |

**PROVIDER INFORMATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Provider ID: |  | | |  | Facility Address: | |  |
|  |  |  |  |  |  |  |
| Facility Name: |  | | |  |  |  |
|  |  |  |  |  |  |  |  |
| Contact Requested: | |  | Yes |  | No |  |  |
| If Yes, provide contact information: | | | | Name: | |  | |
| *(must be an LPHA)* | | | | Title: | |  | |
|  | | | | Phone Number: | |  | |

**REQUEST INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Requestor Name: |  | Requestor Telephone #: | ( ) - |

**Fax To: 1-800-418-4039 Attn: eQHealth FSP Coordinator**

**RECONSIDERATION INFORMATION**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of eQHealth Denial Notification: | / / | | |  |  |  |  | Item for Reconsideration: | |
|  |  |  |  |  |  |  |  |  | FSP Renewal Application | |
|  |  |  |  |  |  |  |  |  |  | |
|  |  |  |  |  |  |  |  |  | Prior Auth Residential | |
|  |  |  |  |  |  |  |  |  |  | |
| Additional Documents submitted? | |  | Yes |  |  | No |  |  | Continued Stay Residential | |
|  |  |  |  |  |  |  |  |  |  | |
|  |  |  |  |  |  |  |  |  |  | |
| Rationale / Medical Reason for Disagreement (type in the textbox below) | | | | | | | | | |
|  | | | | | | | | | |

***IMPORTANT****: Please complete this form and submit it with additional information or documentation to   
support the medical necessity of the denied date(s) of service only. DO NOT fax documentation more than 25 pages. If your documentation is greater than 25 pages, please contact eQHealth at (866) 435 - 8778.*

*An approved request for Certification does not guarantee payment from HFS. When an approval is given, it is the provider’s responsibility to verify the patient’s eligibility on the date of service and to confirm the patient’s continuing need for service.*