INSTRUCTIONS

Completing the eQHealth Solutions Reconsideration Request Form for Prior Authorization of Elective Procedures

|  |
| --- |
| Section I: Participant Information |
| **Recipient Identification #** – Enter the Participant’s number that appears on the IL Medicaid identification card.**Participant Name** – Enter the Participant’s first name, middle initial, and last name as it appears on the IL Medicaid identification card.**Sex** – Indicate the sex of the Participant.**Age** – Enter the age of the Participant at the time service (is to be) was rendered. **Date of Birth** – Enter the month, date, and year of the Participant’s birth. Use two-digit numbers, e.g., 01/04/64. |
| Section II: Provider Information |
| **Hospital IL Medicaid #** – Enter the hospital’s Illinois Medicaid provider number.**Hospital Name** – Enter the name of the hospital that (will render) rendered the treatment.**Physician IL Medicaid #** – Enter the physician’s Illinois Medicaid provider number.**Physician Name** – Enter the first name, middle initial, and last name of the attending (Surgeon) physician.  |
| Section III: Request Information |
| **Request Date** *–* Record the date of the request.**Request Method***–* Indicate whether request submitted by fax, mail or telephone.**Requested By** – Indicate whether the physician or hospital made the request. **Requestor Name** *–* Enter the name of the individual requesting the review.**Requestor Telephone #** *–* Enter the telephone number of the requestor including area code. |
| Section IV: Reconsideration Information |
| **Date of Denial Notification** – Enter the date medical necessity denial letter was issued. **Date of Admission** *–* Enter the date the patient was admitted to the hospital.**Rationale for Request** – Enter the medical basis/rationale for disagreement.**Additional information submitted** – Indicate whether additional information is submitted with the request. |