Reconsideration Request Form for Prior Authorization

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| **RECONSIDERATION TYPE:** |  | ***EXPEDITED- Prior authorization***  |  | * **CABG**
* **Back Surgery**
 |
| PARTICIPANT INFORMATION |
| Recipient ID # (RIN): |  | Sex: |  | Age: |  | Date of Birth: |  |
| Participant Name: |  |  |  |  |  xx/xx/xxxx |
|  | (First) | (MI) | (Last) |  |
| PROVIDER INFORMATION |
| Hospital Medicaid ID: |  | Attending(Surgeon) Physician Medicaid #: |  |
| Hospital Name: |  |  Attending(Surgeon)Physician Name: |  |  |  |
|  |  |  (First) (MI) (Last) |
| Physician Contact Requested? |  | Yes  |  | No |
|  If “Yes”, provide Treating Physician Information:  (no third party contact)  | Name:Phone Number: |
| REQUEST INFORMATION |
| Request Date: |  | Requested By: |  | Hospital |  | Physician |
| Request Method: |  | Fax |  | Mail | Requestor Name: |  |
| Fax: 1-800-418-4039, **Attn: Denial/Reconsideration**Mail: eQHealth Solutions, 2050-10 Finley Rd., Lombard, IL 60148**Attn: Denial/Reconsideration Coordinator** | Requestor Telephone #: |  | Ext. |  |
| RECONSIDERATION INFORMATION |
| Date of Denial Notification: |  |  |  |
| Date of Admission: |  |  |  |
| Rationale / Medical Reason for Disagreement (type in text box below): |
| **Is additional information submitted?** |  | Yes |  | No |
|  |
| *IMPORTANT: Please complete this form and submit it with additional information or documentation to support the medical necessity of the procedure(s).* |

*An approved request for Prior Authorization does not guarantee payment from HFS. When an approval is given, it is the provider’s responsibility to verify the patient’s eligibility for that service.*