
INSTRUCTIONS

Completing the eQHealth Solutions Reconsideration Request Form for HFS Participants

- **Select the type of Reconsideration – Expedited or Standard**

Section I: Participant Information

1. **Recipient Identification #** – Enter the Participant’s number that appears on the IL Medicaid identification card.
2. **Participant Name** – Enter the Participant’s first name, middle initial, and last name as it appears on the IL Medicaid identification card.
3. **Sex** – Indicate the sex of the Participant.
4. **Age** – Enter the age of the Participant at the time service (is to be) was rendered.
5. **Date of Birth** – Enter the month, date, and year of the Participant’s birth e.g., 01/04/64 (2 digit #s)

Section II: Provider Information

1. **Hospital IL Medicaid ID** – Enter the hospital’s Illinois Medicaid provider number (12-digit).
2. **Hospital Name** – Enter the name of the hospital that (will render) rendered the treatment.
3. **Attending Physician IL Medicaid #** – Enter the physician’s Illinois Medicaid provider number.
4. **Attending Physician Name** – Enter the first name, middle initial, and last name of the attending physician.
5. **Request Physician Contact?** – If yes, enter the contact information for the treating physician, including name and phone number with area code.

Section III: Request Information

1. **Request Date** – Record the date of your request.
2. **Request Method** – Indicate whether request submitted by fax or by mail.
3. **Requested By** – Indicate whether the physician or hospital made the request.
4. **Requestor Name** – Enter the name of the individual requesting the review.
5. **Requestor Telephone #** – Enter the telephone number of the requestor including area code.

Section IV: Reconsideration Information

1. **Date of Denial Notification** – Enter the date medical necessity denial letter was issued.
2. **Date of Admission** – Enter the date the patient was admitted to the hospital.
3. **Date of Discharge** – If the patient has been discharged from the hospital, enter the discharge date.
4. **Rationale for Request** – Enter the medical basis/rationale for disagreement.
5. **Additional information submitted** – Indicate if additional information is submitted with request.
Complete the form and submit it with additional information or documentation to support the medical necessity of the denied date(s) of service.