INSTRUCTIONS

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

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| 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. |