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.*