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| Request Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| PARTICIPANT INFORMATION | | |
| Participant Name: Last, First, Middle  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: // | | Medicaid ID #:  Sex:  Age: |
| HOSPITAL/REQUESTOR INFORMATION | | PHYSICIAN’S INFORMATION |
| Hospital’s Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medicaid 12-digit Provider ID #:  Hospital Requestor Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone #: () -  Ext.  email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Attending(Surgeon)  Physician’s Name: Last, First, Middle Initial  Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Zip Code: -  Phone #: () -  Medicaid ID #  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Participant Medicaid ID Number:**  **Participant Last/First/Middle Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: // | | |
| (Proposed) Admission date: // | | |
| ICD-9-CM DIAGNOSIS CODE(S) | NARRATIVE DESCRIPTION(S) | |
| 1. |  | |
| **Scheduled Date** | **ICD-9-CM Procedure Code(s)** | **Procedure Description(s)** |
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| |  | | --- | | **Participant Medicaid ID Number:**  **Participant Last/First/Middle Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: // | | **CLINICAL INDICATIONS** | | Pain/paresthesia/numbness  Yes  No If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Extremity weakness  Yes  No If yes, affected extremity(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Motor/sensory deficit  Yes  No If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Radiculopathy  Yes  No If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Bladder/bowel dysfunction  Yes  No If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Decreased rectal sphincter tone  Yes  No  Activity Modification  Yes  No If yes, date(s)/duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Formal Physical Therapy program Yes  No If yes, date(s)/duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pain with ADL’s  Yes  No If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intractable pain, despite oral analgesic tx.  Yes  No If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NSAID’s  Yes  No If yes, duration/outcome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Epidural injections  Yes  No If yes, date(s)/outcome\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Congenital anomalies of the cervical, thoracic, lumbar area or spinal cord  Yes  No | | | | |
| PAST TREATMENTS | | | |
| List results of any treatments not described in clinical indications section: | | | |
| **Participant Medicaid ID Number:**  **Participant Last/First/Middle Name:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of Birth: //   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | | Labs/Studies/Tests(enter the date and results of pertinent labs, studies & tests) | | | | **Date- if available/applicable** | **Labs/studies/tests** | **Results/Findings** | | // | **EMG** |  | | // |  |  | | // |  |  | | // |  |  | | // |  |  | | X-Rays/Imaging(enter the date and results of X-rays & Imaging) | | | | **Date- if available/applicable** | **X-rays/Imaging** | **Results/Findings** | | // | **CT** |  | | // | **CT-MYL** |  | | // | **MRI** |  | | // | **X-ray:** |  | | // |  |  | | // |  |  | | // |  |  | | // |  |  | | // |  |  |   **Additional Comments:** *Please provide additional information needed to complete prior authorization review.  It is* ***NOT*** *necessary to repeat information that was already provided in other sections of this form. Include a short clinical summary of the participants’ pertinent history and progress.*   |  | | --- | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | | | | |
| |  |  | | --- | --- | | |  | | --- | | **Participant Medicaid ID Number:**  **Participant Last/First/Middle Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: // | | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | | | |
| **HEALTH CARE AND FAMILY SERVICES DISCLAIMER STATEMENT** | | | |
| **eQHEALTH SOLUTION'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.  As an authorized Medicaid provider, I certify that I have reviewed the information submitted for prior authorization. I certify that the information provided is true, accurate, and complete to the best of my knowledge. I understand that services requested herein are subject to review and approval through Healthcare and Family Services’ Utilization Management and Quality Improvement Organization. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution, or may disqualify me as a provider of Medicaid services.**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |

Signature of Requestor Date

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