US FAMILY HEALTH PLAN

Medical Necessity Review/Prior Authorization Request Form

Fax: 866-337-8690 *Mail: eQHealth Solutions*
1431 Greenway Drive
Suite 500
Irving, TX 75038

eQHealth SOLUTIONS

PLEASE PRINT

Request Date: ________________

Requestor's Name: __________________________

Phone #: (☐☐☐)☐☐☐-☐☐☐☐

Fax #: (☐☐☐)☐☐☐-☐☐☐☐

Requesting Provider: __________________________

Requesting Provider NPI: ______________________

Review Type: ☐ Admission/Initial ☐ Inpatient ☐ Retrospective ☐ Outpatient

Pre-determination completed ☐ Yes ☐ No

If yes: ☐ Approved ☐ Denied Date: ______

Out of Network request: ☐ Yes ☐ No

REQUEST DETAILS

Place of Service:

☐ Home ☐ Inpatient ☐ Outpatient

☐ Physician Office ☐ Other ___________

Severity:

☐ Standard (non-urgent) ☐ Expedited/Urgent

By checking the urgent box, you attest that applying the standard review timeframes may seriously jeopardize the member's life, health or ability to regain maximum function or subject the member to severe pain that cannot be adequately managed.

☐ Other _________________________

MEMBER INFORMATION

Member Name: ___________________________________
(Last, First, Middle)

Address: ______________________________________

____

____

Date of Birth: ☐☐ / ☐☐ / ☐☐

Member ID #: ☐☐☐☐☐☐☐☐☐☐-☐☐

Phone #: (☐☐☐)☐☐☐-☐☐☐☐

Sex: ☐ Male ☐ Female ☐ Unknown

Age: ☐☐☐

FACILITY INFORMATION

Facility:____

Address:_______________________________________

Phone #: (☐☐☐)☐☐☐-☐☐☐☐

Fax # : (☐☐☐)☐☐☐-☐☐☐☐

TIN #: ☐☐☐☐☐☐☐☐☐☐

NPI #: ☐☐☐☐☐☐☐☐☐☐
(Required)

Out of Network: ☐ Yes ☐ No

PROCEDURE/SERVICE

Primary Diagnosis: _______________________________

Primary Diagnosis Code: ___________________________

Secondary Diagnosis: _____________________________

Secondary Diagnosis Code: _________________________

Service/Procedure Code: __________________________

Description: ____________________________________

Start Date: ☐☐ / ☐☐ / ☐☐

End Date: ☐☐ / ☐☐ / ☐☐

Units: ____________________

☐ Days ☐ Units ☐ Visits (check one)

Effective: 12/05/2019
Version: 12/04/2019

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SERVICING PROVIDER (e.g. DME or Home Health)	**ADMITTING/SERVICING PHYSICIAN**
Name:______________________	Name: Last, First, Middle ______________________
Address:______________________	Specialty:______________________
Phone #: (☐☐☐)☐☐☐-☐☐☐☐	Address:______________________
Fax # : (☐☐☐)☐☐☐-☐☐☐☐	Phone #: (☐☐☐)☐☐☐-☐☐☐☐
TIN #: ☐☐☐☐☐☐☐☐☐☐	Fax # : (☐☐☐)☐☐☐-☐☐☐☐
NPI #: ☐☐☐☐☐☐☐☐☐☐ **(Required)**	TIN #: ☐☐☐☐☐☐☐☐☐☐
	NPI #: ☐☐☐☐☐☐☐☐☐☐ **(Required)**
Out of Network: ☐ Yes ☐ No	**Out of Network:** ☐ Yes ☐ No

Notes: Please list additional CPT codes, prior treatment history, current treatment plan and other pertinent information in this area.

SUPPORTING DOCUMENTATION

Only submit clinical information that supports the request for service(s) to determine medical necessity or specifically requested by eQHealth Solutions.

Type of Review Request	Documentation
All Types of Review Requests	Documentation not included in the review request form that supports the medically necessity of the requested services.
Urgent Review Requests	Requests can only be submitted as urgent ***if applying the standard review timeframes may seriously jeopardize the member's life, health or ability to regain maximum function or subject the member to severe pain that cannot be adequately managed.***

Disclaimer Statement

eQHealth Solutions certification determination is based on the information provided herein and is not a guarantee of payment or coverage. Benefits are subject to eligibility and limitations at the time of service. Final payment and coverage determinations shall be made in accordance with the terms, conditions, limitations and exclusions as set forth under the US Family Health Plan policy.

Requesting Provider Attestation Statement

I hereby attest that, as a healthcare services provider or provider's representative, an order for the above medical services has been received for the identified member. In addition, I attest that the treatment plan has been approved by the prescribing (ordering) physician.

Printed Name: ______________________

Signature: ______________________

Date: ______________________

UR/Pre-Authorization Contact: 866-560-9069

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