US FAMILY HEALTH PLAN

Fax: 866-337-8690 *Mail:* *eQHealth Solutions UR Dept*
8440 Jefferson Hwy
Suite 101
Baton Rouge, LA 70809

eQ Health 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

lace 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)

PLEASE PRINT

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 #: □□□□□□□□□
Out of Network: ☐ Yes ☐ No	NPI #: □□□□□□□□□ (Required)
	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

QHealth 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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