eq·Health solutions

Request Date: _____

RECIPIENT INFORMATION

Recipient Name: Last, First, Middle

_____

Date of Birth: ☐☐/☐☐/☐☐

Medicaid ID #: ☐☐☐☐☐☐☐☐☐☐

Sex: ☐ Age: ☐☐☐

REQUESTING PROVIDER INFORMATION

Requestor's Name: _____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Ext. ☐☐☐☐

Fax #: (☐☐☐) ☐☐☐-☐☐☐☐

email: _____

Provider Name:

_____

Provider's Medicaid ID #: ☐☐☐☐☐☐☐☐☐
(required)

ORDERING PROVIDER'S NAME

Ordering Provider's Name: Last, First, Middle

_____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Fax #: (☐☐☐) ☐☐☐-☐☐☐☐

Medicaid #: ☐☐☐☐☐☐☐☐☐☐
(required)

NPI: ☐☐☐☐☐☐☐☐☐☐

FI License #: ☐☐☐☐☐☐☐

TYPE OF SERVICE

Indicate the service type for Recipient:

- ☐ Ambulatory Surgery
- ☐ Chiropractic
- ☐ Vision/Optometry
- ☐ Special Services
- ☐ Hearing
- ☐ Advanced Diagnostic Imaging
- ☐ ITP Pump
- ☐ Other (explain) _____

RECONSIDERATION INFORMATION

Date of denial notification: ☐☐/☐☐/☐☐

Date of Start of Service: ☐☐/☐☐/☐☐

Date of completion of services , if applicable: ☐☐/☐☐/☐☐

Are you submitting additional clinical information? Yes ☐ No ☐

REASONS FOR DISAGREEMENT WITH THE DENIAL DETERMINATION

Recipient Medicaid ID#: _____

Recipient Last, First, Middle Name:_____ Date of Birth: _____

Additional Information