Return to:
eQHealth Solutions
Attn: RT Review
5802 Benjamin Center Dr, Ste 105
Tampa, FL 33634
FAX: 855-427-3747
Scanned/**secured** email:
rtservicerequests@eqhs.org

RESPIRATORY SERVICES
MEDICAL NECESSITY REVIEW REQUEST

Medically necessary services will be issued for Code G0238 for 6 months.

I. GENERAL INFORMATION

Recipient Number	Last Name	First Name	Date of Birth

Diagnosis Code _____
Description _____

☐ Admission request
☐ Continued services request
☐ Modification

From date____ Through date____

units/visit _____ Visits per period _____

Period Type ○day, ○week, ○month

Summary of necessity for procedures (check all that apply):

☐ Vent dependent
☐ Requires non-invasive mechanical ventilation (e.g. bilevel positive airway pressure, curiass ventilation) at all times
☐ Other (please describe)_____

Supporting Documentation ***Please refer to the Therapy Services Coverage and Limitations Handbook for supporting documentation requirements)***

All required supporting documentation must be submitted with the review request.

☐ A signed and dated prescription from the PCP, an ARNP or designated PA (required with each review request.)
☐ Evaluation results (required with each initial request)
☐ Re-evaluation results (required for continued service and modification requests)
☐ Plan of Care signed and dated by the ordering provider and therapist. (required for all review requests)
☐ Documentation that the recipient has been examined or received medical consultation by the ordering or attending physician (prior to initiating services and every 180 days thereafter.)

III. PROVIDER INFORMATION

Medicaid Provider Number:_____

I hereby attest that, as the provider or provider representative, an order for services has been received for the recipient. In addition, I attest that the treatment plan has been approved by the provider. A provider who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be subject to the application of sanctions, which include, but are not limited to, fines, suspensions, and termination. In addition, the provider may be prosecuted under federal and/or state criminal laws and may be subject to civil monetary penalties and/or fine.

Signature of Provider:_____ Date:_____

Provider Name: _____ Address:_____

Contact Name:_____ Phone Number:_____ Fax Number:_____

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION DISCLAIMER STATEMENT
eQHealth Solutions certification determination does not guarantee Medicaid payment for services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.