Home Health And Personal Care Services Providers Contact Form

All information must be complete for processing

NOTICE: It is important to notify us immediately when contacts change to ensure effective and timely communications**.**
Check here if this is a request for a change in previously submitted contact information. ☐

Attention: Florida Medicaid Providers of Home Health Services (including Personal Care Services)

Return <u>Completed and Signed</u> Form By Fax or Mail To:
Fax: 855-440-3747
Attention: Customer Service
eQHealth Solutions – Florida Division
5802 Benjamin Center Drive, Suite 105
Tampa, Florida 33634
Phone: 855-444-3747

Provider Name:		
Mailing Address:		
Medicaid Provider #		**NPI:**

Please complete the following table and provide the requested information for <u>one</u> individual for each Contact Type.

Home Health and Personal Care Services Contact Type Descriptions:

1. *Administrator or Chief Executive Officer (CEO) – This person in is charge of the facility. This individual will receive general correspondence from eQHealth Solutions, provider bulletins, and contact forms.*
2. Assigned eQHealth Liaison – *This person will be the main contact for receipt of information from eQHealth Solutions regarding the Medicaid Comprehensive Utilization Management Program requirements for home health and personal care services, including prior authorization review. Also this person is someone we can contact to obtain necessary information regarding the facility or provider.*
3. *Quality Improvement and Management – This person is the individual who is directly responsible for quality management and improvement activities.*
4. *Sample of Medical Records – This is the person who will receive requests for medical records for any medical record review.*
5. *System Administrator – This person is responsible for management of user IDs for facility or provider representatives' access to eQHealth's prior authorization review system, eQSuite. This includes day-to-day administration of creation, deletion, and modification to user information and rights.*
6. *Other contact types listed on the form are sometimes copied on correspondence or sent information that may be useful to them.*

Contact Type	Contact Name	Prof. Suffix	Title	Mailing Address (<u>If different from above</u>)	Email Address	Telephone and Fax Numbers
Administrator or CEO						T: F:
Assigned eQHealth Liaison						T: F:
Quality Improvement and Management Contact						T: F:
Medical Records						T: F:

Contact Type	Contact Name	Prof. Suffix	Title	Mailing Address (If different from above)	Email Address	Telephone and Fax Numbers
System Administrator						T: F:
Director of Utilization Review or Case Management (if different from Assigned eQHealth Liaison)						T: F:
Medical Director						T: F:
Chief Financial Officer						T: F:
Compliance Officer						T: F:

NOTE: Prior authorization review emails and request for additional information will be sent directly to the individual that submits the request for review.

FORM MUST BE SIGNED BY THE HOME HEALTH and PERSONAL CARE SERVICES PROVIDER AGENCY ADMINISTRATOR OR CEO

_____

Administrator or CEO (PLEASE PRINT NAME & TITLE)

Signature: _____ Date: _____