Advanced Diagnostic Imaging Request for eQSuite® Access

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. ☐

Return Completed and Signed Form
By Fax: 855-440-3747, Attention: Provider Outreach
Email (signed, scanned forms only)
provideroutreach@eqhs.org

Handwritten forms cannot be accepted

Provider Name:			
Mailing Address:			
Provider Medicaid Number:		**Provider Type:**	**NPI:**

Please complete the following table and provide the requested information for each Contact Type.

Advanced Diagnostic Imaging Contact Type Descriptions:

1. *Administrator or Chief Executive Officer (CEO), This individual has the authority to sign this form.*
2. *Assigned eQHealth Liaison – This person will be the main contact for receipt of information regarding the Medicaid Comprehensive Utilization Management Program prior authorization requirements for ADI services.*
3. *System Administrator – This person is responsible for management of user IDs for staff access to the prior authorization review system, eQSuite®. This includes day-to-day administration of creation, deletion, and modification to user information and rights.*

Contact Type	Contact Name	Prof. Suffix	Title	Mailing Address (If different from above)	Email Address	Telephone and Fax Numbers
Administrator or CEO						T: F:
Assigned eQHealth Liaison						T: F:
System Administrator						T: F:

FORM MUST BE SIGNED BY THE ADMINISTRATOR OR CEO

Signature: _____

_____
Administrator or CEO (PLEASE PRINT NAME & TITLE)

Date: _____