Return to:
eQHealthSolutions,Inc
Atten: Utilization Review Dept.
Fax: 855-440-3747

OUT OF STATE INPATIENT / OUTPATIENT AUTHORIZATION REQUEST

Please check box:

Hospital
☐ Prior Authorization
☐ Post Authorization

Physician
☐ Prior Authorization
☐ Post Authorization

☐ **Other** (excludes dental)
Post Authorization Date of Service: _____

I. General Information			
Recip. Number- 10 digits	Last Name	First Name	Date of Birth

Diagnosis	Procedure Code	Procedure Description	Quantity

EXPLANATION OF NECESSITY FOR PROCEDURES (Attach supportive x-rays, lab reports, operative notes, and discharge summaries etc. if indicated)

II. PROVIDER INFORMATION	**AGENCY USE ONLY:**
Medicaid Provider Number:	Date:
I certify that the information given in this form is a true and accurate indication of the procedures requested. All other treatment to correct this problem has been exhausted.	☐ Approved PA Number Proc. Code Amount ☐ Denied Reason
Signature of Provider Date Provider Name: Address:	Additional Info. Specify: Reviewed by:
Contact Name: Contact Phone Number:	Signature Date Approved authorizations do not guarantee payment but are contingent upon recipient and provider Eligibility on the Date of Service, and services being provided not more than 120 days from the date of authorization.