Return to:
eQHealthSolutions,Inc
Atten: Inpatient Dept.
Fax: 855-427-3747

OUT OF STATE INPATIENT 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

Medicaid Provider Number: _____

I certify that the information given in this form is a true and accurate medical indication for the procedures requested. All other treatment to correct this problem has been exhausted.

_____ _____
Signature of Provider Date

Provider Name: _____
Address: _____

Contact Name: _____

Contact Phone Number: _____

AGENCY USE ONLY:

Date: _____

☐ Approved PA Number _____
Proc. Code _____
Amount _____

☐ Denied Reason _____

Additional Info. Specify: _____

Reviewed by:

_____ _____
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.