Return to:
eQHealth Solutions
Attn: Exempt Services
Fax:855-440-3747

MULTI-SPECIALTY SERVICES
PRIOR AUTHORIZATION REQUEST

I. GENERAL INFORMATION

Recipient Number	Last Name	First Name	Date of Birth

Diagnosis Description	Procedure Code Description	Quantity

Please circle the appropriate pricing modifier:

24, 25, 26, 50, 51, 52, 54, 55, 56, 59, 62, 66, 76, 77, 78, 79, 80, LT/RT, QK, QS, TC

Summary of necessity for procedures: Please refer to the applicable Medicaid Handbook for required supporting documentation and covered services. Please check the applicable fee schedule to verify if the service requires prior authorization. (Attach supportive x-rays, lab reports, operative notes, and discharge summaries, etc., if indicated and additional information). Please include the Botox PA Form for J0585.

II. SERVICE CATEGORY: Please check the service category below and indicate if this is for Prior Authorization or Post Authorization or Retrospective Review (if applicable)

(Check Category)	Prior Authorization	Post Authorization* or Retrospective Review	* If Post Authorization Indicate Date of Service
☐ Ambulatory Surgery	☐	☐	____/____/____
☐ Vision / Optometry	☐	☐	____/____/____
☐ Hearing	☐	☐	____/____/____
☐ ITB Pump	☐	☐	____/____/____
☐ Special Services	☐	☐	____/____/____
☐ Other:_____ _____	☐	☐	____/____/____

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.