ABS Automated Benefit Services
AUTOMATED BENEFIT SERVICES, INC.

Prior Authorization Request Form
Fax to 586-693-4829

eQ Health SOLUTIONS

Please be aware that you may submit all inquiries for prior authorization requests via the eQSuite® Provider Portal at https://precertification.eqhs.com/. ***eQSuite® Provider Portal is an all access entry into your prior authorization requests and determinations.*** It is an approved and preferred option for providers to submit prior authorization requests, provide clinical information, and receive determination outcomes electronically. It allows for direct communication and in certain instances, immediate determinations. A brief registration process is required if this is your first time logging in to the portal.

For questions about using the portal, please contact eQHealth Solutions at: 866-356-3666

Request Date: ____ /_____ /_____

Review Type: ☐ Admission/Initial ☐ Inpatient ☐ Retrospective ☐ Outpatient

MEMBER INFORMATION

Member Name: Last, First, Middle (*please PRINT*)

_____

Address: _____

_____

_____

Date of Birth: _____ / _____ / _____

Member ID #: _____

Phone #: _____

Birth Sex: ☐ Male ☐ Female ☐ Unknown

Age: _____

Please enter Admission / Start date of Service:

_____ / _____ / _____

REQUESTOR CONTACT INFORMATION

Requestor's Name: _____

Phone #: _____

Fax #: _____

Place of Service:

☐ Home ☐ Inpatient ☐ Outpatient

☐ Physician Office ☐ Other _____

Severity:

☐ Standard (non-urgent) ☐ Expedited/Urgent

☐ Other _____

By checking the Expedited/Urgent box, you attest that applying the standard review timeframes may seriously jeopardize the member's life, health or ability to regain maximum function, or subject the member to severe pain that cannot be adequately managed.

REQUESTING PHYSICIAN / PROVIDER

Name: Last, First, Middle _____

Address: _____

_____

_____

Specialty: _____

Phone #: _____

Fax #: _____

TIN #: _____
(Required)

NPI #: _____

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FACILITY INFORMATION	PROCEDURE
Facility:_____ Address:_____ _____ _____ Phone #: _____ Fax # : _____ TIN #: _____ **(Required)**	Primary Diagnosis: _____ Primary Diagnosis Code: _____ Procedure Code: _____ Description: _____ Start Date: ____ / ____ / ____ End Date: ____ / ____ / ____ Units: _____ ☐ Days ☐ Units ☐ Visits (check one)

Clinical Summary Information- prior treatment history, current treatment plan and other pertinent information, etc.

SUPPORTING DOCUMENTATION

The following documentation is not required but may be submitted. Only submit clinical information that supports the request for service(s) to determine medical necessity or specifically requested by eQHealth Solutions.

Type of Review Request	Documentation
All Types of Review Requests	Documentation not included in the review request form that supports the medically necessity of the requested services.
Urgent Review Requests	Requests can only be submitted as urgent ***if applying the standard review timeframes may seriously jeopardize the member's life, health or ability to regain maximum function, or subject the member to severe pain that cannot be adequately managed.***

Disclaimer Statement

eQHealth Solutions certification determination does not guarantee payment for services. Eligibility for and payment of services are subject to all terms and conditions and limitations of the Summary Plan Description.

Requesting Provider Attestation Statement

I hereby attest that, as a healthcare services provider or provider's representative, an order for the above medical services has been received for the identified member. In addition, I attest that the treatment plan has been approved by the prescribing (ordering) physician.

Printed Name: _____

Signature: _____

Date: _____

UR/Pre-Authorization Contact: 866-356-3666