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| Request Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PARTICIPANT INFORMATION |
| Participant Name: Last, First, Middle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: [ ] [ ] /[ ] [ ] /[ ] [ ]  | Medicaid ID #: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Sex: [ ]  Age: [ ] [ ] [ ]  |
| HOSPITAL/REQUESTOR INFORMATION  | PHYSICIAN’S INFORMATION |
| Hospital’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medicaid 12-digit Provider ID #: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  Hospital Requestor Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: ([ ] [ ] [ ] ) [ ] [ ] [ ] -[ ] [ ] [ ] [ ]  Ext. [ ] [ ] [ ] [ ] email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Attending(Surgeon)Physician’s Name: Last, First, Middle Initial Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code: [ ] [ ] [ ] [ ] [ ] -[ ] [ ] [ ] [ ] Phone #: ([ ] [ ] [ ] ) [ ] [ ] [ ] -[ ] [ ] [ ] [ ] Medicaid ID # [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Participant Medicaid ID Number:** [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  **Participant Last/First/Middle Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: [ ] [ ] /[ ] [ ] /[ ] [ ]  |
| (Proposed) Admission date: [ ] [ ] /[ ] [ ] /[ ] [ ]  |
| ICD-9-CM DIAGNOSIS CODE(S) | NARRATIVE DESCRIPTION(S) |
| 1.  |  |
| **Scheduled Date** | **ICD-9-CM Procedure Code(s)** | **Procedure Description(s)** |
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| **Participant Medicaid ID Number:** [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  **Participant Last/First/Middle Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: [ ] [ ] /[ ] [ ] /[ ] [ ]  |
|  **CLINICAL INDICATIONS** |
| Pain/paresthesia/numbness [ ]  Yes [ ]  No If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Extremity weakness [ ]  Yes [ ]  No If yes, affected extremity(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Motor/sensory deficit [ ]  Yes [ ]  No If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Radiculopathy [ ]  Yes [ ]  No If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Bladder/bowel dysfunction [ ]  Yes [ ]  No If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Decreased rectal sphincter tone [ ]  Yes [ ]  NoActivity Modification [ ]  Yes [ ]  No If yes, date(s)/duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Formal Physical Therapy program [ ] Yes [ ]  No If yes, date(s)/duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pain with ADL’s [ ]  Yes [ ]  No If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intractable pain, despite oral analgesic tx. [ ]  Yes [ ]  No If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NSAID’s [ ]  Yes [ ]  No If yes, duration/outcome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Epidural injections [ ]  Yes [ ]  No If yes, date(s)/outcome\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Congenital anomalies of the cervical, thoracic, lumbar area or spinal cord [ ]  Yes [ ]  No  |

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| PAST TREATMENTS |
| List results of any treatments not described in clinical indications section: |
| **Participant Medicaid ID Number:** [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  **Participant Last/First/Middle Name:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of Birth: [ ] [ ] /[ ] [ ] /[ ] [ ]

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| Labs/Studies/Tests(enter the date and results of pertinent labs, studies & tests) |
| **Date- if available/applicable** | **Labs/studies/tests** | **Results/Findings** |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  | **EMG** |  |
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| X-Rays/Imaging(enter the date and results of X-rays & Imaging) |
| **Date- if available/applicable** |  **X-rays/Imaging** | **Results/Findings** |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  | **CT** |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  | **CT-MYL** |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  | **MRI** |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  | **X-ray:** |  |
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**Additional Comments:** *Please provide additional information needed to complete prior authorization review.  It is* ***NOT*** *necessary to repeat information that was already provided in other sections of this form. Include a short clinical summary of the participants’ pertinent history and progress.*

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| **Participant Medicaid ID Number:** [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  **Participant Last/First/Middle Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: [ ] [ ] /[ ] [ ] /[ ] [ ]  |

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| **HEALTH CARE AND FAMILY SERVICES DISCLAIMER STATEMENT** |
| **eQHEALTH SOLUTION'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM. As an authorized Medicaid provider, I certify that I have reviewed the information submitted for prior authorization. I certify that the information provided is true, accurate, and complete to the best of my knowledge. I understand that services requested herein are subject to review and approval through Healthcare and Family Services’ Utilization Management and Quality Improvement Organization. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution, or may disqualify me as a provider of Medicaid services.** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

 Signature of Requestor Date

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