|  |
| --- |
| Request Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| MEDICAID 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 #:  [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Requestor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: ([ ] [ ] [ ] ) [ ] [ ] [ ] -[ ] [ ] [ ] [ ]  Ext. [ ] [ ] [ ] [ ] email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Attending(Surgeon)Physician’s Name: Last, First, Middle InitialStreet Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code: [ ] [ ] [ ] [ ] [ ] -[ ] [ ] [ ] [ ] Phone #: ([ ] [ ] [ ] ) [ ] [ ] [ ] -[ ] [ ] [ ] [ ] Medicaid ID # [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  |
| **Participant Medicaid ID Number:** [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  Participant Last/First/Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: [ ] [ ] /[ ] [ ] /[ ] [ ]  |
| PREADMISSION INFORMATION |
| (Proposed) Admission date: [ ] [ ] /[ ] [ ] /[ ] [ ]  |
| ICD-9-CM DIAGNOSIS CODE(S) | NARRATIVE DESCRIPTION(S) |
| 1.  |  |
| **Scheduled Date** | **ICD-9-CM Procedure Code(s)** | **Procedure Description(s)** |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
|

|  |
| --- |
| **CLINICAL INDICATIONS** |

 |
| Stenosis in one or more vessels [ ]  Yes [ ]  No If yes, vessels affected/percentage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Failed PCI [ ]  Yes [ ]  NoGraft(s) occluded [ ]  Yes [ ]  NoCoronary Artery Anomalies [ ]  Yes [ ]  No Unstable angina [ ]  Yes [ ]  No If yes, still present with treatment [ ]  Yes [ ]  NoDiabetes Mellitus [ ]  Yes [ ]  NoHeart failure/Congestive Heart Failure [ ]  Yes [ ]  No If yes, is it newly diagnosed [ ]  Yes [ ]  No |
|  |
| 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: [ ] [ ] /[ ] [ ] /[ ] [ ]  |
| Labs/Studies/Tests(enter the date and results of pertinent labs, studies & tests) |
| **Date- if available/applicable** | **Lab/Study/Test** | **Results/Findings** |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  | **Heart Catheterization** |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  | **EKG** |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  | **Stress Test** |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
|

|  |
| --- |
| X-ray & Imaging(enter the date and results of x-rays and imaging) |
| **Date- if available/applicable** |  **X-Ray/Imaging**  | **Results/Findings** |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  | **ECHO** |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  | **TEE** |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
| [ ] [ ] /[ ] [ ] /[ ] [ ]  |  |  |
|  |  |  |

 |
| **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.*­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
|  |
| **HEALTHCARE 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 |