For eQHealth Use Only:
Tracking #: _____ **URC #:** _____ **TAN:** _____ **Final Letter Date:** _____

eQHealth Solutions
Reconsideration Request Form for HFS Participants

PARTICIPANT INFORMATION

Recipient ID # (RIN): _____ Sex: ____ Age: _____ Date of Birth: ____/_____/____

Participant Name: _____ Patient Account # (*if applicable):* _____
(First) (MI) (Last)

PROVIDER INFORMATION

Hospital IL Medicaid #: _____ Physician IL Medicaid #: _____

Hospital Name: _____ Physician Name: _____
(First) (MI) (Last)

Physician Telephone #: (_____) _____-_____

REQUEST INFORMATION

Request Date: _____/_____/_____ Requested By: ☐ Hospital ☐ Physician

Request Method: ☐ Fax ☐ Mail Requestor Name: _____

Requestor Telephone #: (____) _____-_____ Ext. ____

RECONSIDERATION INFORMATION

Date of Denial Notification: _____/_____/_____ Date of Administrative Denial: _____/_____/_____

Date of Admission: _____/_____/_____ Date of Discharge: _____/_____/_____

Rationale/Medical Reason for Disagreement:_____

_____

_____

_____

_____

_____

_____

Is additional information being submitted? ☐ Yes ☐ No

NOTE: If the denial determination was made on an Admission Certification or Concurrent/Continued Stay Review Request, a copy of the medical record for date(s) of denial must be submitted with this Reconsideration Request Form.

An approved request for Certification of Admission and/or Continued Stay does not guarantee payment. When an approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service and to confirm the patient's continuing need for service.

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INSTRUCTIONS

Completing the eQHealth Solutions Reconsideration Request Form for HFS Participants

Section I: Participant Information

1. **Recipient Identification #** – Enter the Participant's number that appears on the IL Medicaid identification card.
2. **Participant Name** – Enter the Participant's first name, middle initial, and last name as it appears on the IL Medicaid identification card.
3. **Sex** – Indicate the sex of the Participant.
4. **Age** – Enter the age of the Participant at the time service (is to be) was rendered.
5. **Date of Birth** – Enter the month, date, and year of the Participant's birth. Use two-digit numbers, e.g., 01/04/64.
6. **Patient Account Number** – Enter the Participant's hospital account number. *Optional field for hospital use only.*

Section II: Provider Information

1. **Hospital IL Medicaid #** – Enter the hospital's Illinois Medicaid provider number.
2. **Hospital Name** – Enter the name of the hospital that (will render) rendered the treatment.
3. **Physician IL Medicaid #** – Enter the physician's Illinois Medicaid provider number.
4. **Physician Name** – Enter the first name, middle initial, and last name of the attending physician.
5. **Physician Telephone #** – Enter the telephone number of the attending physician, including area code.

Section III: Request Information

1. **Request Date** – Record the date of the request.
2. **Request Method** – Indicate whether request submitted by fax, mail or telephone.
3. **Requested By** – Indicate whether the physician or hospital made the request.
4. **Requestor Name** – Enter the name of the individual requesting the review.
5. **Requestor Telephone #** – Enter the telephone number of the requestor including area code.

Section IV: Reconsideration Information

1. **Date of Denial Notification** – Enter the date medical necessity denial letter was issued.
2. **Date of Administrative Denial –** Enter the date of the Administrative Denial – Failure to Obtain Concurrent/Continued Stay Review, if applicable.
3. **Date of Admission** – Enter the date the patient was admitted to the hospital.
4. **Date of Discharge –** If the patient has been discharged from the hospital, enter the discharge date.
5. **Rationale for Request** – Enter the medical basis/rationale for disagreement.
6. **Additional information submitted** – *Indicate whether additional information is submitted with the request. If the denial determination was made on an Admission Certification or Concurrent/Continued Stay Review request, a copy of the medical record for the date(s) denied must be submitted with the Reconsideration Request Form.*