LSU-First Medical Necessity Review
Fax – 1- 855-558-3723

eq·Health solutions

Request Date: _____

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

MEMBER INFORMATION

Member Name: Last, First, Middle

_____

Address: _____

_____

_____

Date of Birth: ☐☐/☐☐/☐☐

Member ID #: ☐☐☐☐☐☐☐☐☐☐☐☐

Sex: ☐ 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: ☐ Emergent (ER)

☐ Urgent ☐ Other

REQUESTING PHYSICIAN / PROVIDER

Name: Last, First, Middle _____

Address: _____

_____

Specialty: _____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Fax # : (☐☐☐) ☐☐☐-☐☐☐☐

TIN #: ☐☐☐☐☐☐☐☐☐☐
(Required)

NPI #: ☐☐☐☐☐☐☐☐☐☐

FACILITY INFORMATION

Facility: _____

Address: _____

_____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Fax # : (☐☐☐) ☐☐☐-☐☐☐☐

TIN #: ☐☐☐☐☐☐☐☐☐☐

(Required)

DIAGNOSIS / PROCEDURE

Primary Diagnosis: _____

Primary Diagnosis Code: _____

Procedure Code: _____

Description: _____

Start Date: ☐☐/☐☐/☐☐

End Date: ☐☐/☐☐/☐☐

Units: ☐☐☐☐ (Days, Units, Visits) Circle

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.

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 LSU First 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: _____

Customer Care Contact: 855-326-3466