Ascension
Personalized Care

APC precertification/PA fax:
586-693-4768

Medical specialty precertification/prior authorization request

Please 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. You can submit all inquiries. For questions about using the portal and UR/prior authorizations, please contact eQHealth Solutions at 866-356-3666.

Ascension Personalized Care member ID: ___________________________

Please indicate: ☐ Start of treatment - Start date: _____/_____/_____
☐ Continuation of treatment - Date of last treatment: _____/_____/_____

Precertification requested by: __________________________ Phone: ________________ Fax: ______________

A. PATIENT INFORMATION				
First Name:	Last Name:		DOB:	
Address:	City:		State:	ZIP:
APC ID:	Phone:		Email:	
Patient Current Weight: lbs or kgs	Patient Height: inches or cms		Allergies:	

B. PRESCRIBER INFORMATION				
First Name:	Last Name: *(Check One):* M.D. D.O. N.P. P.A.			
Address:	City:		State:	ZIP:
Phone:	Fax:			
NPI #: (REQUIRED)	Tax ID: (REQUIRED)			
Contact Name:	Contact Email:		Contact Phone:	

C. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:

☐ Self-Administered ☐ Physician's Office

☐ Outpatient Infusion Center Phone:____________________

Center Name:______________________________

☐ Home Infusion Center Phone:____________________

Agency Name:______________________________

Administration Code(s) (CPT):______________________________

Address:______________________________

NPI (REQUIRED): ______________________________

Tax ID (REQUIRED): ______________________________

Place of Dispensing (Provider/Pharmacy):

☐ Physician's Office ☐ Retail Pharmacy

☐ Hospital Based Medication ☐ Clinic Medication

☐ Specialty Pharmacy ☐ Other: ______________

Name: ______________________________

Address: ______________________________

Phone: ______________________________

Fax: ______________________________

NPI: ______________________________

DIAGNOSIS INFORMATION		
Diagnosis:	Staging:	ICD-10:

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E. CLINICAL INFORMATION – Provide medical necessity documentation for the requested medication including other medications tried (attach supporting documentation).

Clinical documentation to support medical necessity should be faxed back along with the completed form.

F ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*:__Date:____/________/________

G. MEDICATION(S)/ONCOLOGY OR COMPLEX REGIMEN

1 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): *(if available)*	
2 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): *(if available)*	
3 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): *(if available)*	
4 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): *(if available)*	
5 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): *(if available)*	
6 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): *(if available)*	
7 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy: