SmartHealth

Referral Request Form

(Service not available in Ascension network)

Must be submitted by an Ascension Network Provider

Fax to 586-693-4768

Ascension

Ascension Insurance Utilization Management Gateway

Please be aware that you may submit all inquiries for referrals via the eQSuite® Provider Portal at https://precertification.eqhs.com/. ***eQSuite® Provider Portal is an all access entry into your referral requests and determinations.*** It is an approved and preferred option for providers to submit referral requests, provide clinical information, and receive determination outcomes electronically. It allows for direct communication and in certain instances, immediate determinations. A brief registration process is required if this is your first time logging in to the portal.

For questions about using the portal, please contact us at: 866-356-3666

Request Date: ____ /_____ /_____

Review Type: ☐ Service not available ☐ Appointment availability

MEMBER INFORMATION

Member Name: Last, First, Middle (*please PRINT*)

_____

Address: _____

_____

_____

Date of Birth: _____ / _____ / _____

Member ID #: _____

Phone #: _____

Birth Sex: ☐ Male ☐ Female ☐ Unknown

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:

☐ Standard (non-urgent) ☐ Expedited/Urgent

☐ Other _____

By checking the Expedited/Urgent box, you attest that applying the standard review timeframes may seriously jeopardize the member's life, health or ability to regain maximum function, or subject the member to severe pain that cannot be adequately managed.

ASCENSION NETWORK REFERRING PHYSICIAN / PROVIDER

Name: Last, First, Middle _____

Address: _____

_____

_____

Specialty: _____

Phone #: _____

Fax #: _____

TIN #: _____

(Required)

NPI #: _____

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FACILITY/PROVIDER INFORMATION	PROCEDURE
Facility: _____	Primary Diagnosis: _____
Address: _____	Primary Diagnosis Code: _____
_____	Procedure Code: _____
_____	Description: _____
	Start Date: ____ / ____ / ____
Phone #: _____	End Date: ____ / ____ / ____
Fax # : _____	Units: _____
TIN #: _____ (Required)	☐ Days ☐ Units ☐ Visits (check one)

Clinical Summary Information- prior treatment history, current treatment plan and other pertinent information, etc.

SUPPORTING DOCUMENTATION

Only submit clinical information that supports the referral request for service(s) to determine medical necessity or specifically requested by Ascension Insurance Utilization Management Gateway.

Type of Review Request	Documentation
All Types of Referral Requests	Documentation not included in the referral request form that supports the medically necessity of the requested services.
Urgent Review Requests	Requests can only be submitted as urgent ***if applying the standard review time frames may seriously jeopardize the member's life, health or ability to regain maximum function, or subject the member to severe pain that cannot be adequately managed.***

Disclaimer Statement

Ascension Insurance Utilization Management Gateway 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 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: _____

UR/Referral Contact: 866-356-3666