Request for eQSuite® Access

All information must be complete for processing

Check here if this is a request for a change in previously submitted contact information. ☐

Notice: Pleae notify us immediately when contact information changes to ensure effective and timely communications and HIPAA compliance.

Return Completed and Signed Form

By Fax: 866-940-4288
Attn: Provider Outreach
Or Email (signed, scanned forms only) to:
provideroutreach@eqhs.org

Handwritten forms cannot be accepted

Please complete the following table and provide the requested information for each Contact Type.

A separate form must be completed for each unique provider Medicaid number. e.g. each physician within a group practice must request a separate logon

Provider Name:			
Mailing Address:			
Provider Medicaid Number:		**Provider Type:**	**NPI:**

Contact Type Descriptions:

1. *Administrator or Chief Executive Officer (CEO.) This individual has the authority to sign this form.*
2. *Assigned eQHealth Liaison – This person will be the main contact for receipt of information regarding prior authorization requirements for services.*
3. *System Administrator – This person is responsible for management of user IDs for staff access to the prior authorization review system, eQSuite®. This includes day-to-day administration of creation, deletion, and modification to user information and rights.*

Contact Type	Contact Name	Prof. Suffix	Title	Mailing Address (If different from above)	Email Address	Direct Telephone and Fax Numbers
Administrator or CEO	dfaf					T: F:
Assigned eQHealth Liaison						T: F:
System Administrator						T: F:

IMPORTANT INFORMATION (please read before signing)

UNAUTHORIZED ACCESS TO eQSUITE® IS PROHIBITED BY LAW

By signing this form, you are attesting that you understand that accessing eQSuite® is for the sole purpose of conducting Utilization Review and that each logon will be used only by the individual to whom it assigned.

Unauthorized or improper use of the eQSuite™ product(s) may result in disciplinary action, as well as civil and criminal penalties.

SAFEGUARDING & LIMITING ACCESS TO EXCHANGED DATA
I agree to establish and implement proper safeguards against unauthorized use of eQSuite®. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained shall be used solely in accordance with HIPAA, HITECH Act, Omnibus Rule and the Privacy Act of 1974 as amended [5 U.S.C. § 552a].

FORM MUST BE SIGNED BY THE ADMINISTRATOR OR CEO*

Signature: _____

_____
Administrator or CEO (PLEASE PRINT NAME & TITLE) Date: _____