

PRIOR AUTHORIZATION REQUEST FORM

Please send the completed form and any additional information to eternalHealth by fax to:

- **866-337-8686** for standard requests
- **866-815-4297** for expedited requests*

*By submitting this form to the expedited fax number, you are certifying that the 72-hour standard review time is necessary to prevent serious jeopardy to the life or health of the member or the member's ability to regain maximum function.

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for the requested prior authorization(s). Please attach supporting documentation (medical records, progress notes, lab reports, radiology studies etc) to support medical necessity of the services being requested. An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures.

Member Information

Member Name (Last, First, MI)	
Product Name	
Member ID #	
Member Date of Birth (MM/DD/YYYY)	
Member Phone Number	

Provider Information

<u>Ordering/Requesting Provider</u>		<u>Admitting/Servicing Provider (if different)</u>	
Provider Name		Provider Name	
Provider ID #		Provider ID #	
Provider Address		Provider Address	
Provider Phone Number		Provider Phone Number	
Provider Fax Number		Provider Fax Number	

Facility Information (if applicable)

Facility Name			
Facility Tax ID #			
Facility Address			
Facility Phone Number		Facility Fax Number	

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Service Request			
Inpatient Services			
<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Hospice	<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Long Term Acute Care
<input type="checkbox"/> Out-of-Network	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Surgery (Type): _____
<input type="checkbox"/> Transplant	<input type="checkbox"/> Other: _____		
Date of Admission		Number of Days Requested	
For Long Term Acute Care or Skilled Nursing, what level of care is being requested?			
Outpatient Services			
<input type="checkbox"/> Ambulance, non-emergent	<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> DME	<input type="checkbox"/> Home Health
<input type="checkbox"/> Hospice	<input type="checkbox"/> Infusion Services	<input type="checkbox"/> Residential Services	<input type="checkbox"/> Substance Abuse Services
<input type="checkbox"/> Surgery (Type): _____	<input type="checkbox"/> Transportation	<input type="checkbox"/> Other: _____	
Requested Start date (mm/dd/yyyy)		Requested End date (mm/dd/yyyy)	
Number of Days/Sessions/ Units/Visits Requested and Frequency			
For Ambulance (non-emergent), please indicate the type of ambulance service being requested.		<input type="checkbox"/> Air	<input type="checkbox"/> Ground
For Home Health, please indicate the number of hours per week are being requested. Please specify hours by type of service (i.e., 5 hours/week of PT). Please include signed physician order and assessment.			
Detail of Inpatient/ Outpatient Services			
Product/Service Description (Include applicable CPT/HCPCS Codes)			
Diagnosis & Diagnosis Code (ICD-10 Standard codes. Enter at least one)			
Signature of Requestor			
Name of Individual Completing this Form (Last, First, MI)			
Signature of Individual Completing this Form (By typing your name here, you attest that the information given is true and accurate to the best of your knowledge)			
Today's Date			

NOTE: The prior authorization does not guarantee payment. Payment is subject to eligibility on the date of service, plan benefits, limitations and exclusions, pre-existing condition limitations, and member liability under the plan.