eternalHealth

PRIOR AUTHORIZATION REQUEST FORM

Please indicate the urgency of the request and send the completed form and any additional information to eternalHealth by fax:

- ☐ Standard Request
- ☐ Expedited Request

- **866-337-8686** for standard requests
- **866-215-4297** for expedited requests*

*By submitting this form to the expedited fax number, you are certifying that the 72-hour expedited 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			
Ordering/Requesting Provider		**Admitting/Servicing Provider (if different)**	
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

☐ Behavioral Health	☐ Hospice	☐ Hospitalization	☐ Long Term Acute Care
☐ Out-of-Network	☐ Rehabilitation	☐ Skilled Nursing Facility	☐ Surgery (Type): _____
☐ Transplant	☐ 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

☐ Ambulance, non-emergent	☐ Behavioral Health	☐ DME	☐ Home Health
☐ Hospice	☐ Infusion Services	☐ Residential Services	☐ Substance Abuse Services
☐ Surgery (Type): _____	☐ Transportation	☐ 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.	☐ Air ☐ 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.
The plan will only approve authorized services for up to 6 months. A prior authorization request can be submitted after the initial 6 months for additional services with appropriate supporting documentation.