Clear Spring Health
3601 SW 160th Ave Suite 450
Miramar, FL 33027
Fax: 866-613-0157
Email: outpatientutilization @eonhp.com

PRE-SERVICE AUTHORIZATION REQUEST FORM

Instructions for Submitting a Request

Please read all instructions before completing this form.

Clear Spring Health Care requires that providers obtain prior authorization before rendering services. If any items on the Clear Spring Health Care Prior Authorization List are submitted for payment without obtaining an authorization, the related claim or claims will be **denied** as provider liability. The provider will have 60 days from the date of the claim denial to appeal and supply supporting documentation required to determine medical necessity. For members participating in an HMO**.**

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify member benefits and/or coverage; 4) ask whether a service requires prior authorizations; 5) request prior authorizations of a prescription drug; or 6) request a referral to an out of network physician, facility or other health care provider.

Expedited Reviews are urgent authorization requests that meet the following criteria:

a. Could seriously jeopardize the health of the member
   or
b. In the opinion of a physician with knowledge of the member's medical condition, the member would suffer severe pain that cannot be adequately managed without the care or treatment that is the subject of the request

IMPORTANT REMINDERS

1. Verify member's eligibility and benefits prior to submitting a request
2. Provide supporting medical documentation (i.e. progress notes, lab reports, study results, etc.) along with authorization request
3. All applicable fields are required. If all information is not provided, this will cause a delay in the authorization process
4. Do not send duplicate requests, as this may delay the process
5. Fax completed Service Requests to 866-613-0157 If unable to fax, you may email your request to outpatientutilization@eonhp.com.
6. Claims should be submitted to: Clear Spring Health Care, P.O. Box 4048, Scranton, PA, 185-9875. Electronic Claims Submission, Payor ID: 66009 Clear Spring

Please contact Utilization Management at 877-384-1241, if you have any questions.

******Non-Participating providers require an authorization for all services rendered. If you are not already in negotiations with Clear Springs Health Care and would be interested in contracting with us, please contact Provider Relations Department at (877)384-1241.***

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☐ STANDARD REQUEST ☐ EXPEDITED REQUEST

Patient Information (*Required Field)

*PATIENT NAME		*DATE OF BIRTH	*MEMBER ID
*ADDRESS	*CITY	*STATE	*ZIP CODE	*PHONE #

Services Requiring Authorization (*Required Field)

*DATE OF THE REQUEST

☐ NEW REQUEST ☐ CONTINUED REQUEST FOR SERVICE (Extension)

* Last Date of Service, for continued services: _____

☐ OFFICE VISIT	☐PT/ST/OT	☐GENETIC TESTING
☐ AMBULATORY SURGERY	☐HOME HEATH SERVICES	☐SPECIALTY LABS
☐ DURABLE MEDICAL EQUIPMENT (DME)	☐INFUSION THERAPY / INJECTIONS	☐TRANSPLANT EVALUATION
☐ ORTHOTICS & PROSTHETICS	☐HIGH TECH RADIOLOGY (MRI/CT/MRA/PET)	☐HOSPICE
☐ DIAGNOSTIC OUTPATIENT SERVICES	☐MENTAL HEALTH/SUBSTANCE ABUSE	☐DIALYSIS
☐ CHIROPRACTIC	☐CARDIAC REHAB	☐**OTHER:** _____

Requesting Provider Information (*Required Field)

PROVIDER NAME	*NPI #	*TAX ID #
GROUP / PRACTICE NAME	*GROUP NPI #	*GROUP TAX ID #
OFFICE CONTACT PERSON / PERSON COMPLETING FORM	*PHONE #	*FAX #

Services Requested (*Required Field)

*PRINCIPAL DIAGNOSIS - ICD 10	SECONDARY DIAGNOSI – ICD 10	*SERVICE START DATE	*SERVICE END DATE
*CPT/HCPC PROCEDURE CODES		☐ HOURS ☐ DAYS ☐ UNITS ☐ VISITS ☐ DOSAGE NUMBER/AMOUNT:	

Servicing Provider or Facility ☐ Participating ☐ Non-Participating

☐ SERVICING PROVIDER IS THE SAME AS REQUESTING PROVIDER ☐ W-9 INCLUDED (Mandatory for Non-Par Providers)

Non-Par providers must complete the below information at it will appear on the claim and W9

PROVIDER / FACILITY NAME	*NPI #	*TAX ID #
ADDRESS	*PHONE #	*FAX #
GROUP / PRACTICE NAME	*GROUP NPI #	*GROUP TAX ID #
OFFICE CONTACT PERSON / PERSON COMPLETING FORM	*PHONE # (if different from above)	*FAX # (if different from above)

Attestation for Non-Participating Providers (*Required Field)

THIS AUTHORIZATION SERVES AS A ONE TIME OUT OF NETWORK AGREEMENT AT THE RATE OF 100% MEDICARE ALLOWABLE FOR NON-PARTICIPATING PROVIDER. THIS AUTHORIZATION REQUEST WILL BE VALID FOR 30 DAYS.

*PROVIDER SIGNATURE:_____ *DATE:_____