3620 Enterprise Way Miramar, FL 33025 | inpatientutilization@eonhp.com | outpatientutilization@eonhp.com
Inpatient Fax: 866-611-1957 **Service Request Fax: 866-613-0157**

PRIOR AUTHORIZATION REQUEST FORM

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, Non-Participating providers require an authorization for all services rendered. If you wish to contract with Clear Spring Health Care, please reach out to our Provider Relations Department: (877) 384-1241**

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.

Additional Information and Instructions

Expedited Reviews: Request an expedited review for a member with a life-threatening condition, or for a member who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

WARNING

Authorizations will not be processed without:

- **Supporting clinical documentation (i.e. medical records, progress notes, lab reports, etc.) to determine medical necessity.**
- **Non-par providers – must have this form completed and a W9**

Please contact Utilization Management at 877-384-1241, if you have any questions. Once your treatment has been rendered to member, please submit your claim to:

Clear Spring Health Care

PO Box 4048

Scranton, PA 18505-9875

Electronic Claim Submissions, Payor ID: **66009 Clear Spring Health**

If you are not already in negotiations with **Clear Spring Health Care** for a direct contract and would be interested in contracting with us, please contact Provider Relations Department at (877) 384-1241.

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Section I. Patient Information

Today's Date	**Patient DOB (month/day/year)**
Patient Name	**Member Plan ID or Medicare ID**

Section II. Service Type Requiring Authorization

☐ **Standard/Routine** (14 Calendar days)	☐ **New Request** ☐ **Extension** * Last Date of Service, if an extension _____

Ambulatory/ Outpatient Services	**Outpatient Therapy**	**Durable Medical Equipment**	**Home Health / Hospice**	**Inpatient / Observation**
☐ Surgery/Procedure ☐ Infusion/Oncology Drugs ☐ Diagnostic ☐ Provider Office **Ancillary** ☐ Chiropractic ☐ IVF/ART	☐ Occupational ☐ Physical ☐ Speech Therapy ☐ Pulmonary ☐ Cardiac Rehab	☐ Prosthetic Device ☐ Orthotic Device ☐ Purchase ☐ Rental	☐ Home Health _____Skilled Nursing _____PT / OT / ST _____HHA _____MSW ☐ Hospice ☐ Infusion Therapy ☐ Respite Care	☐ Acute Medical / Surgical ☐ Acute Rehab ☐ Long Term Acute care ☐ Skilled Nursing Facility ☐ Observation

Other – please specify:

Section III. Services Requested (CPT / HCPCS / ICD 10 Codes)

Principal Diagnosis Description **ICD-10 Codes:**	**Secondary Diagnosis Description** **ICD-10 Codes:**	**Service Start Date**	**End Date**

Planned Procedure (CPT/HCPCS Codes) and Description:
# of Units Being Requested: _____
☐ Hours ☐ Days ☐ Months ☐ Visits ☐ Dosage

Section IV. Requesting Provider or Facility

Name		**Contact Person**	
Phone	**Fax**	**NPI**	**Tax ID**

Section V. Servicing Provider or Facility

☐ Participating ☐ Non-Participating (Non-Par providers must complete below information as it will appear on your claim and W9)

Name		**Group Name**	**Group NPI**
Address		**NPI**	**Tax ID**
Phone	**Fax**	**Specialty**	**Contact Person**

Section VI. Attestation for Non-Par Providers

This Authorization serves as a one time out of network agreement at the rate of 100% Medicare allowable for NON-Participating providers. Authorizations will be valid for 30 days.

Provider Signature_____
Date: