



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.

Eon Health requires that providers obtain prior authorization before rendering services. If any items on the Eon 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. **Non-Participating providers require an authorization for all services rendered.** If you wish to contract with Eon Health, please reach out to our **Provider Relations Department: 866-638-2631**

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 866-689-8761, if you have any questions.

Once your treatment has been rendered to member, please submit your claim to:

EON HEALTH PLAN
P.O. Box 21517
Eagan, MN 55121
Electronic Claim Submissions:
Payor ID # 73780 (Emdeon)

If you are not already in negotiations with EON HEALTH PLAN for a direct contract and would be interested in contracting with us, please contact Provider Relations Department at 866-638-2631.



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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				
<input type="checkbox"/> Standard/Routine (14 Calendar days) <input type="checkbox"/> Expedited/ STAT (within 72 hours)		<input type="checkbox"/> New Request <input type="checkbox"/> Extension * Last Date of Service, if an extension _____		
Ambulatory/Outpatient Services <input type="checkbox"/> Surgery/Procedure <input type="checkbox"/> Infusion/ Oncology Drugs <input type="checkbox"/> Diagnostic <input type="checkbox"/> Provider Office Ancillary <input type="checkbox"/> Chiropractic <input type="checkbox"/> IVF/ART	Outpatient Therapy <input type="checkbox"/> Occupational <input type="checkbox"/> Physical <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Pulmonary <input type="checkbox"/> Cardiac Rehab	Durable Medical Equipment <input type="checkbox"/> Prosthetic Device <input type="checkbox"/> Orthotic Device <input type="checkbox"/> Purchase <input type="checkbox"/> Rental	Home Health / Hospice <input type="checkbox"/> Home Health _____ Skilled Nursing _____ PT / OT / ST _____ HHA _____ MSW <input type="checkbox"/> Hospice <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Respite Care	Inpatient / Observation <input type="checkbox"/> Acute Medical / Surgical <input type="checkbox"/> Acute Rehab <input type="checkbox"/> Long Term Acute care <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Observation
Other – please specify:				
Section III. Services Requested (CPT / HCPCS / ICD 10 Codes)				
Principal Diagnosis Description		Secondary Diagnosis Description		Service Start Date
ICD-10 Codes:		ICD-10 Codes:		End Date
Planned Procedure (CPT/HCPCS Codes) and Description:				
# of Units Being Requested: _____				
<input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Visits <input type="checkbox"/> Dosage				
Section IV. Requesting Provider or Facility				
Name		Contact Person		
Phone	Fax	NPI	Tax ID	
Section V. Servicing Provider or Facility				
<input type="checkbox"/> Participating <input type="checkbox"/> 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 <u>100% Medicare allowable</u> for NON-Participating providers. Authorizations will be valid for 30 days.				
Provider Signature _____			Date: _____	