Tenet Health System Desert, Inc. - EA Program
Patient Designation and Reimbursement Request Form

Section 1: To be completed by Specialty Physician
Complete this section to receive reimbursement for each Covered Patient.
The information below must be submitted to the Program Liaison within 21 days of the patient's discharge.
The Program Liaison will validate patient's eligibility and return, via fax, this form as an acknowledgment of inclusion in the EA Program. Please complete the information below for each patient or affix a standard hospital label below. If the patient is currently an in-patient, please leave the discharge date blank.

Patient Episode of Care Complete ☐ **YES** ☐ **NO**

Date(s) of Service	
Physician Name	
Physician Phone #	
Patient Name	
Date of Birth	
Medical Record Number	
Discharge Date	
Physician Comments	

By signing below, Specialty Physician certifies and agrees to the following requirements:

- I agree this patient should be paid under the EA Program if deemed eligible.
- I have not billed and will not bill this patient or any other party (such as insurance carrier, etc.) or their insurance unless instructed by the Program Liaison.
- I did not refer this patient to the Hospital nor do I have an office partner who referred this patient to the Hospital. I do not currently have, and have not had an established ongoing office practice relationship with this patient in the last 12 months, nor do I have an office partner who currently has or had had an established ongoing practice relationship with this patient in the last 12 months.

Specialty Physician Signature ________________________________ **Date**______________________

Please fax this form to the Program Liaison. The Program Liaison will verify eligibility of the submitted Covered Patient. Upon patient discharge, the services documented on this patient will be coded and you will receive a list of codes for review.

NAME: Mary Jane Friga, Program Liaison	**Phone: 760.323.6241** **Fax: 760.323.6426** **Email: Mary.Friga@tenethealth.com**

Section 2: To be completed by EA Program Liaison:

Patient is designated as a Covered Patient? **Yes** **No**

If No please provide reason/comments ____

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Program Liaison Signature____________________________________ **Date** _________________

Form Faxed to Physician Office by _____________________________ **Date** _________________

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