



Prior Authorization Request Form
(Excluding DME/Medical Supplies)

Fax: (602) 778-3331

Phone: (602) 778-3330
1-866-406-0955

Date of Request: _____

Member Information

Member Name: _____ Address: _____
Phone Number: _____ City: _____ State: _____ Zip: _____
Patient ID Number: _____ DOB: ____/____/____ Age: _____
Medicare [] Yes [] No Other Insurance: _____

Requesting Physician Information

Requesting Physician: _____ Name of Person Completing Form: _____

Phone Number: _____ RETURN AUTHORIZATION TO THIS FAX #: _____

Diagnosis: _____ ICD-9: _____ CPT Code(s): _____ HCPC Code(s): _____

Authorization Request

Referring To: _____ Frequency: _____ Duration: _____

Address: _____ Phone Number: _____

Facility/Hospital Name: _____

Address: _____ Expected Date of Service: _____

[] Office [] Inpatient Services [] Outpatient Services [] 23 Hour Short Stay/Observation

Describe symptoms, duration, tried and/or failed treatment, relevant lab, diagnostic test (if possible please fax in supporting documentation with request):

HEALTH PLAN USE ONLY

Approved []
Authorization Number: _____ Valid From: _____ to _____ Expiration Date

Denied [] Denial Reason: _____

Medical Director Signature

PA Nurse/Tech Signature

Date

Authorization is subject to eligibility on date of service. If member is determined to be ineligible on date of service, the member may be responsible for these services. To ensure proper payment for services rendered, referral provider/facility must verify eligibility on the date of service.