



Prior Authorization Request Form
(Excluding DME/Medical Supplies)

Fax: (602) 778-3331

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

Date of Request: [ ] Routine [ ] STAT/URGENT
Please allow 14 days for Routine request. STAT request can take up to 72 hours/3 business days.

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: Person Completing Form/Call Back Number:
Phone Number: FAX AUTHORIZATION NUMBER TO:
Diagnosis: ICD-9: CPT Code(s): HCPC Code(s):

Authorization Request

Referring To: Total Number of Visits: 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

Tech/PA Nurse 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.