

ARIZONA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I – SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:
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SECTION II – REASON FOR REQUEST

Review Type: <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency:	
Request Type: <input type="checkbox"/> Initial <input type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #:	

SECTION III – REVIEW

Expedited/Urgent Review Requested: By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient’s ability to regain maximum function.

Signature of Prescriber or Prescriber’s Designee: _____

SECTION IV – PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Member Name (if different from Section I):	Member ID #:	Group Name or Number:	

SECTION V – PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Service Care Provider’s Name:	
Requesting Provider’s Signature and Date (if required):		Phone:	Fax:

SECTION VI – SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version__)	Code

Inpatient
 Outpatient
 Provider Office
 Observation
 Home
 Day Surgery
 Other: _____

Physical Therapy
 Occupational Therapy
 Speech Therapy
 Cardiac Rehab
 Mental Health/Substance Abuse

Number of Sessions: _____
 Duration: _____
 Frequency: _____
 Other: _____

Home Health:
 Order Attached? Yes No
 Nursing Assessment Attached? Yes No

Number of Visits: _____
 Duration: _____
 Frequency: _____
 Other: _____

SECTION VII – CLINICAL DOCUMENTATION (Attach additional documentation as needed)