

Prior Authorization Form

FAX: 480-588-8061

Incomplete forms will be faxed back to sender:

Instructions: <ul style="list-style-type: none"> Please validate patient eligibility and benefits prior to rendering services FAX completed forms to (480)588-8061 or 1-833-665-1252 Submit all clinical documentation such as progress notes/labs/radiology with requests For questions Medical Management Department at (800) 250-6647 or (480) 400-0027 					Eligibility Verified Yes No	
<i>Payment for services is dependent upon the patient's eligibility at the time services are rendered. Copays, coinsurance and/or deductibles may apply. Pre-certifications are valid for the date range specified on this form.</i>						
Member Name		DOB		(Health Plan) ID Number		
Member Address (Street, City, Zip Code)				Member Phone Number		
Member E Mail:				Member Alt Number		
Requesting Provider		Practice Phone Number		Practice Fax Number		
Member Requested? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Prepared by		Date Sent		
<input type="checkbox"/> Routine/Standard Request: Decisions will be rendered within 5 business days from receipt of all necessary information						
<input type="checkbox"/> Urgent Request: Decisions will be rendered within 72 hours from receipt of all necessary information. A request is urgent if the routine/standard turn-around-time could seriously jeopardize the life, health or ability to regain maximum function or subject the member to sever pain that cannot be managed without requested treatment						
Facility / Provider Name				Phone Number		
Facility / Provider Address (Street, City, Zip Code)				Fax Number		
Facility/ Provider E Mail:						
Tax ID		NPI		Expected Date-of-Service	Inpatient Length of Stay	
Diagnosis	ICD-10 Code	Procedure or Equipment		Procedure Code	Units	
Reason for request (Please submit all pertinent documentation with request)						
For ICP UM use only						
Pre-Certification Number		Date Range		Initials	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	
<input type="checkbox"/> Pend Additional Information			<input type="checkbox"/> Retro-Approval (Services rendered without a Pre-Certification)			
Comments: HIPAA Notice: The information contained in this form may contain confidential and legally privileged information. It is only for the use of the individual or entity named above. If the recipient of this form is not the recipient addressed on the form, you are hereby notified that any dissemination, distribution or copying of the attached document(s) is strictly prohibited. If you have received this in error, please immediately notify the sender by telephone and return the form to the sender.						
Org.11/17/ Rev.						