HEALTHCARE SERVICE
Prior Authorization Form
FAX: (602) 864-5308

Ordering Providers are required to send medical documentation supporting the requested service.

Member Name (Last, First)	Member ID#	DOB	Date of Request

Ordering Provider Name	NPI#	TIN#

Ordering Provider Address

Office Contact Person	Direct Phone #	Fax #

Diagnosis 1 (ICD-10 code)	Diagnosis 2 (ICD-10 code)	Diagnosis 3 (ICD-10 code)

- STANDARD (up to 14 calendar days) No Signature Required.
- EXPEDITED (up to 72 hours) 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.

Ordering Provider Signature	Date

☐ Inpatient ☐ ASC ☐ Outpatient ☐ Office	Specialist Name (Last, First)	Specialty

Name of Facility (if applicable)	Date of service

Address	NPI#	TIN#	Phone #

Name of Procedure	CPT code 1	CPT code 2	CPT code 3	CPT code 4
	CPT code 5	CPT code 6	CPT code 7	CPT code 8

☐ Physical Therapy	☐ Occupational Therapy	☐ Speech Therapy	☐ Home Health	☐ Office
_______ # of visits/units	_______ # of visits/units	_______ # of visits/units	_______ # of visits/units	_______ # of visits

Contracted Ancillary Service Request (DME; O&P; Equipment) and HCPCS Code (or attach list of codes and costs)

Medication Request for Administration for Physician Office Administration

Name of Medication (and J-code)	Dosage	Quantity/Amount	Refills (<12)

Sig/Instructions	Please choose one: ☐ Buy and Bill ☐ CVS Specialty Pharmacy

List Medications Tried/When

List Medications Contraindicated/Reason

Provider Signature	Date

Updated on 4/16/2024