ARIZONA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I – SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:

SECTION II — REASON FOR REQUEST

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	
Request Type: ☐ Initial ☐ 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:	☐ Male ☐ Female
Member Name (if different from Section I):	Member ID #:	Group Name or Number:	

SECTION V — PROVDER 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: **N/A** Duration: **N/A** Frequency: **N/A** Other: **N/A**

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

Number of Visits: **N/A** Duration: **N/A** Frequency: **N/A** Other: **N/A**

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