Prior Authorization Request - Non Emergent

Please fax your request to (480)304-3036

FAILURE TO PROVIDE SUFFICIENT CLINICAL INFORMATION OR FAILURE TO COMPLETE THE AUTHORIZATION FORM WILL RESULT IN A DELAY, A DENIAL OR THE NONPROCESSING OF YOUR REQUEST.

Date:_____

Patient Information: It is important to note that an eligibility and benefits inquiry should be completed first to confirm eligibility, verify coverage, and determine whether or not prior authorization is required by the member's plan.		
Last Name:	First Name:	DOB:
Policy #:	Group:	Eligibility Verification Date:
Address:		
State:	Zip Code:	Phone:

Referring/Ordering Provider Information:		
Referring/Ordering Provider:		
Complete Address:		
Phone:	Fax:	NPI:
Tax ID:	Office Contact:	

Services Requested (including Facility/Company/Office/DME/ Therapy information):		
☐ Inpatient ☐ Outpatient ☐ Ambulatory Surgical Center ☐ Office ☐ DME ☐ Therapy		
Description of Requested Service(s):		
CPT(s) / HCPCS **including Units**:		
ICD10:		
Facility/Company/DME/Therapy/Office Name:		
Facility/Office Tax ID:	Facility/Office NPI:	
Scheduled Date of Service **or** Requested Date Range:		
For same day or next day procedures please call (877)587-2700		

Disclaimer:
An **authorization** is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary per member policy benefits.