INTEGRATED HEALTHCARE MANAGEMENT
Prior Authorization Request Form

Please fax your request to (480)304-3036
All sections must be completed and the supporting medical records attached for the request to be accepted for processing.

Date:_____

Patient Information: Prior to submitting for authorization, an eligibility and benefits inquiry should be completed first to confirm eligibility and benefits.		
Last Name:	First Name:	DOB:
Policy #:	Group:	Patient Phone:
Complete Address:		
State:	Zip Code:	
Referring/Prescribing/ Ordering Provider Information:		
Provider Name:		
Complete Address:		
Phone:	Fax:	
Tax ID:	NPI:	
Services Requested:		
Description of Requested Service(s):		
CPT(s) and/or HCPCS:		
Units:		
ICD10:		
Scheduled Date of Service **or** Requested Service Date Range:		
Place of Service :		
□ **Inpatient** □ **Outpatient** □ **Ambulatory Surgical Center** □ **Office** □ **Other (DME, Therapy)**		
Servicing Facility or Office:		
Servicing Facility Name:		
Servicing Facility Address:		
Phone Number:		
Facility/Office Tax ID:	Facility/Office NPI:	
Contact Information for person(s) submitting this request for authorization:		
Contact Name:	Phone:	Fax:
Disclaimer:		
An authorization is not a guarantee of coverage or payment. Members must be eligible at the time services are rendered. Services must be a covered benefit and are subject to contractual terms, limitations, exclusions, coordination of benefits as well as any other provisions of the member's medical plan. Services must also be medically necessary per member policy benefits.		