## ARIZONA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I – SUBMISSION									
Subscriber Name:			Phor	ne:		Fax:	Date:		
SECTION II — REASON FOR REQUEST									
Review Type:   Non-Urgent Urgent				Clinical Reason for Urgency:					
Request Type: ☐ Initial ☐ Extension/Renewal/Amendme				Prev. Auth. #:					
SECTION III — REVIEW				•					
Expedited/Urgent Review review time frame may ser function.									m
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:					
(				or oup real.					
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 Da		Start Date	En	d Date	Diagno	sis 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									
☐ Home Health: Order Attached? ☐ Yes ☐ No Nursing Assessment Attached? ☐ Yes ☐ No									
Number of Visits: Duration: Frequency: Other:									
SECTION VII — CLINICAL DOCUMENTATION (Attach additional documentation as needed)									