Douglas A. Ducey, Governor
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FEE-FOR-SERVICE AUTHORIZATION REQUEST FORM

(One Member Per Form Please)

♦ Mandatory Fields must be completed or information will be returned.

♦ TYPE OF ACUTE SERVICE REQUESTED

☐ **Prior Authorization**
- ☐ Acute Medical I/P *MR#* _____
- ☐ Acute Medical O/P *MR#* _____
- ☐ Surgical Request
- ☐ DME
- ☐ Therapy
- ☐ Home Health

☐ **LTC Acute**
- ☐ NF
- ☐ I/P

☐ **Behavioral Health**
- ☐ TRBHA
- ☐ BHS Other

☐ **Tribal ALTCS**
- ☐ DME
- ☐ Home Modification
- ☐ Above Level of Care
- ☐ Beds
- ☐ NF (Special Rates)
- ☐ Assisted Living-Behavorial Health

☐ **Transportation**

☐ **Dental**

♦ RECIPIENT NAME: _____

♦ AHCCCS ID (9 digits): A☐☐☐☐☐☐☐☐☐

♦ PROVIDER NAME: _____

♦ PRIOR AUTHORIZATION #: _____

♦ PROVIDER PHONE #: _____

♦ PROVIDER NPI: (10 digits) ☐☐☐☐☐☐☐☐☐☐

♦ PROVIDER FAX #: _____

♦ AHCCCS ID: (6 digits)
(Atypical Providers Only) ☐☐☐☐☐☐

♦ DIAGNOSIS: _____
(Transportation Use R68.89)

♦ DATES OF SERVICE: _____

*CPT/HCPCS/ CDT/ REV Code	Modifier:	Units:	Tiers: ☐ ICU ☐ Routine	Date:

*If CPT/HCPCS are BR (Non-Capped) price is needed (Code/Price): _____

TRANSPORT: TRIP COUNT: _____ (One Way=1 Round Trip=2)
TRIP FROM: _____
TRIP TO: _____

REASON FOR TRIP: _____

COMMENTS: _____

Return Fax # Prior Authorization 602-256-6591 Transportation 602-254-2431 LTC 602-254-2426 BHS 602-364-4697