

ARIZONA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES - AMBETTER

SECTION I – SUBMISSION

Submit the Ambetter PA form via website [Click on this Link and select to Add Files](#)
 Or, fax to 1-877-612-7066 or 480-666-0248. For any questions please call 1-888-705-5274.

Subscriber Name:	Phone:	Fax:	Date:
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SECTION II – REASON FOR REQUEST

Review Type: <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency:
Request Type: <input type="checkbox"/> Initial <input type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #:

SECTION III – REVIEW

<input type="checkbox"/> 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:
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SECTION IV – PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Member Name (if different from Section I):	Member ID #:	Group Name or Number:	

SECTION V – PROVIDER INFORMATION

Requesting Provider or Facility			Service Provider or Facility		
Name:			Name:		
NPI:	TIN:	Specialty:	NPI:	TIN:	Specialty:
Phone:		Fax:	Phone:		Fax:
Contact Name:		Phone:	Service Care Provider’s Name:		
Requesting Provider’s Signature & 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 10)	Code

Inpatient Outpatient Provider Office Observation Home Day Surgery Other:

Skilled Nursing Physical Therapy Occupational Therapy Speech Therapy Home Health Aide
 MSW Cardiac Rehab Mental Health/Substance Abuse

Number of Sessions: Duration: Frequency: Other:

Home Health: Order Attached? Yes No Nursing Assessment Attached? Yes No No of Visits:

Duration: Frequency: Other:

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

ALL REQUIRED FIELDS MUST BE COMPLETED TO AVOID A REJECTED FORM. COPIES OF SUPPORTING CLINICAL INFORMATION REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at time services are rendered. Services must be covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures. Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.