

DENTAL PRIOR AUTHORIZATION / SPECIALIST REFERRAL FORM

Fax 602-674-6677
7878 N. 16th Street, #105
Phoenix, AZ 85020

Member Name:	Member ID:	Member DOB:
Requesting Physician/Dentist:	Phone#: ()	Fax#: include area code ()
Contact Person:	Phone #: ()	Extension:
		Date of Request:

Services Requested (explain):

Justification for services (this field is mandatory)

X-rays are required to determine medical necessity. Please resubmit this form with x-rays.

Authorization Number: _____ **Expiration Date:** _____ **Initial:** _____

Authorization is for: _____

Please Note: An authorization number is not a guarantee of payment. Eligibility must be verified prior to rendering services. Please direct any questions to PHP Dental Prior Authorization Coordinator: (602) 824-3878

Fax requests to (602) 674-6677

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