



Phoenix Health Plan

Serving AHCCCS members for over 25 years

Phone (602) 824-3760 or (800) 747-7997

Fax (602) 674-6678



Abrazo Advantage Health Plan (HMO)

An Affiliate of Abrazo Health Care

Phone (602) 824-3900 or (888) 864-1114

Fax (602) 674-6678

7878 N. 16<sup>th</sup> St, Ste 105  
Phoenix, AZ 85016

(Select Health Plan by Checking Corresponding Box above)

**PRIOR AUTHORIZATION REQUEST FORM**

|                       |  |                  |  |   |  |
|-----------------------|--|------------------|--|---|--|
| Member Name:          |  | Member ID:       |  | Member DOB:   |  |
| PCP Name:             |  | Other Insurance: |  |   |  |
| Requesting Physician: |  | NPI:             |  | <input type="checkbox"/> PA Request is for my office<br><input type="checkbox"/> Other Office |  |
| Date of Request:      |  |                  |  |   |  |
| Contact Person:       |  | Phone #: ( )     |  | Extension:      Fax#: include area code ( )   |  |
| DIAGNOSIS:            |  |                  |  | ICD-9 Code:   |  |

**SUPPORTING DOCUMENTATION MUST BE SUBMITTED WITH REQUEST IN ORDER TO BE PROCESSED**

Request Type:  Routine  Time Sensitive  Expedited ("Life or Limb Threatening")  Non-contracted Provider

|   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Referral to Specialist: (Physicians First and Last Name)   |  | Specialty:  |  |
| Address:  |  | Phone# ( )  |  |
| <input type="checkbox"/> Initial Consultation   | <input type="checkbox"/> Follow up visit(s) #: | Date of Service:  |  |
| <input type="checkbox"/> Surgery/Procedure: (Description)   |  | CPT Code(s):  |  |
| Name/Address of Facility:   |  | <input type="checkbox"/> Inpatient<br><input type="checkbox"/> Outpatient |  |
| Date of Service:  |  |   |  |
| <input type="checkbox"/> DME/Orthotics/Prosthetics: (Description)   |  | HCPCS Code(s):  |  |
| <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy            # of visits: _____            Initial eval date: |  |   |  |
| Comments:   |  |   |  |
| <b>PLEASE ATTACH SUPPORTING DOCUMENTATION, PROGRESS NOTES, H&amp;P, LAB / TEST RESULTS</b>  |  |   |  |

Limitations: This reference number is not a guarantee of payment. Payment for covered services is limited to those specified on this form and is dependent upon the member eligibility at the time of services.

**AREA BELOW FOR PHP/CC and AAHP USE ONLY**

|          |                                   |                                 |            |                   |                  |
|----------|-----------------------------------|---------------------------------|------------|-------------------|------------------|
| Date:    | <input type="checkbox"/> Approved | <input type="checkbox"/> Denied | Signature: | Reference Number: | Expiration Date: |
| COMMENT: |                                   |                                 |            |                   |                  |

Health Care Information is personal and sensitive information related to a person's health care. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

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