Banner University Health Plans

Today's Date: _____

Medical Prior Authorization Form

For all Outpatient Services and Elective Inpatient Surgery and Procedures, Fax to (520) 874-3418 or (866) 210-0512 (please only submit to one fax number).

For all Acute Urgent Admit Notifications and Post Acute (SNF/Rehab/LTAC) admissions, Fax to (520) 874-3420.

Submission Type: ☐ AHCCCS ☐ Medicare

Health Plan: ☐ Banner – University Family Care/ACC ☐ Banner – University Family Care/ALTCS ☐ Banner – University Care Advantage (HMO D-SNP)

Member Name: Last_____ **First**_____ **MI**____

Date of Birth: _____ **Member ID#:** _____

☐ **Inpatient** ☐ **Outpatient** ☐ **Home** ☐ **Office**

Provider making this request (Name & Provider Type):

_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

NPI: _____ **TID:** _____

Phone #: _____

☐ **In-Network** ☐ **Out-of-Network**

Provider to perform the request (if applicable):

_____

Specialty Type: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

NPI: _____ **TID:** _____

Continuity of Care: ☐ **Yes** ☐ **No**

***Name/Direct Contact (Requesting Provider office):**

_____

Backline #: _____ **Ext:** _____

Fax #: _____

Office Email: _____

If member is currently in an active course of treatment, please enter number of months remaining and description of treatment:

Facility Information (Outpatient/Inpatient Only)

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____

NPI: _____

TID: _____

Procedure Requested: _____

Description: _____

Date of Procedure (if sched): _____

HCPC/CPT Code: _____

HCPC/CPT Code: _____

ICD-10 Code: _____

ICD-10 Code: _____

Expedite - Defined as member's life, health, or ability to regain maximum function is in serious jeopardy if determination is not made in the standard timeframe. Request must include supporting documentation to substantiate an expedited review.

Explanation Required: