THE UNIVERSITY OF ARIZONA
HEALTH PLANS

Prior Authorization Form

Fax: (520) 874-3418 or (866) 210-0512

Please include ALL pertinent clinical information with your Prior Authorization request submission.

Health Plan: ☐ UHM ☐ MHP ☐ UCA ☐ MCA ☐ UFC

Date: _____

Requesting Provider/Specialty or PCP:

_____

Address:_____

City: _____ State: _____ Zip: _____

Phone: _____

NPI or Tax ID: _____

Direct Contact/Backline for Requesting Provider:

_____

Phone: _____

Fax: _____

☐ **Standard (up to 14 days for approval)**

☐ **Expedited (up to 72 hours for approval)**

*Providers must use the "Expedited" only when medically necessary.

Please Note: Inappropriate Expedited requests may be downgraded to Standard by UAHP.

☐ Inpatient ☐ In-Office

☐ Outpatient ☐ Home

Facility to be used: _____

Address/Phone: _____

_____

NPI/TID: _____

Member Name: _____

Date of birth: _____

Member ID#: _____

First and last name of the specialist consult to:

_____

Specialty Type:_____

Address: _____

City: _____ State: _____ Zip: _____

NPI or Tax ID: _____

OON Provider: ☐ Yes ☐ No

Date scheduled (if known): _____

Procedure requesting:

_____

CPT Code: _____

CPT Code: _____

CPT Code: _____

CPT Code: _____

Number of visits: ____ Date of Procedure: _____

Diagnosis ICD-10 Code: _____

Diagnosis ICD-10 Code: _____

Diagnosis ICD-10 Code: _____

Diagnosis ICD-10 Code: _____

Comments: