



**Treatment Authorization Request**  
Ph 602.778.1800 (Options 5, 6) Fax 602.778.1838



AHCCCS

DDD

ONECare

Urgent

Routine

Retroactive

**Patient Information**

Member Name:		Date of Birth:	
Member Address (Street)			
Member Address (City, State, Zip)			Male <input type="checkbox"/> Female <input type="checkbox"/>
Member ID:			
Requesting Physician's Name: (PLEASE PRINT)			
Office Contact Name:		Phone:	Fax:

**Service Information**

Referred To:			
Date of request:		Specialty:	
Provider Address:		Phone:	Fax:
Hospital Name:		Other:	

**Service(s) Requested**

<input type="checkbox"/> Hospital Admit Anticipated LOS:	<input type="checkbox"/> Hospital Outpatient	<input type="checkbox"/> ASC	<input type="checkbox"/> In-Office Proc/Testing	<input type="checkbox"/> Consult Only	<input type="checkbox"/> Follow-up Visits (Attach Relevant Data, Notes, Tests, Etc.)	<input type="checkbox"/> Health Education
Requested Service/Procedure:				CPT 4 Code(s)		Unit(s)
Diagnosis:				ICD 9 Code(s) (required):		
Requesting extension of auth # (please explain):						

**Submission of appropriate documentation with your initial request will expedite processing of your request**

**Please include:**  Office Notes  X-ray Reports  Other Diagnostic Tests  
 Lab Results  Specialist Consult Notes

Authorization for specialist office visits are valid for a consultation and 2 follow up visits unless otherwise noted:

Status: <input type="checkbox"/> Approved <input type="checkbox"/> Modified <input type="checkbox"/> Deferred <input type="checkbox"/> Denied			Criteria utilized provided upon request
<b>If the treating or referring physician needs to discuss the case with a physician reviewer; please call Medical Mgmt 602.778.1800 (Option 5, 6)</b>			
Auth#:	Date Approved:	Date Auth Exp:	
Comments:			

**AUTHORIZATION DOES NOT GUARANTEE PAYMENT.** Authorization is subject to member eligibility and benefit coverage on date of service. If the member is determined to be ineligible on date of service, does not have benefit coverage for the service or has exceeded benefit limits, the member may be responsible for the service. To ensure proper payment for services rendered, the provider/facility must verify eligibility or benefits on the date of service. Payment will not be made for unauthorized services. All services must be ordered/performed by contracted providers unless an out of network authorization is obtained. Please send specialist findings to the PCP. This authorization is good for 90 days unless otherwise noted.