Banner University Health Plans
Banner – University Family Care

Behavioral Health Prior Authorization Form

Today's Date: _____

Health Plan:

- ☐ Banner – University Family Care (ACC)
- ☐ Banner – University Family Care (ALTCS)
- ☐ Banner – University Care Advantage (HMO SNP)

** Please attach ALL pertinent clinical Information with your submission. **

Fax Completed form to:

(520) 694-0599

Requesting Provider Name & Type:
_____

Address:_____

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

Phone: _____

NPI ID: _____

Tax ID: _____

Direct Contact/Backline for Requesting Provider:

_____

Backline #: _____

Fax #: _____

Member Name Last: _____

Member Name First: _____

Date of birth: _____

Member ID#: _____

First and Last Name of the Specialist Consult to:

Specialty Type: _____

Address: _____

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

NPI #: _____

Tax ID #: _____

AHCCCS ID #: _____

OON Provider: □ Yes □ No

Procedure Requesting: _____

HCPC/CPT Code/Units: _____

HCPC/CPT Code/Units: _____

HCPC/CPT Code/Units: _____

HCPC/CPT Code/Units: _____

Diagnosis ICD-10 Code: _____

Diagnosis ICD-10 Code: _____

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

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

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

Place of Service:

Facility Information (Outpatient/Inpatient Only)

Name: _____

Address: _____

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

Phone: _____

NPI ID: _____

Tax ID: _____

Comments:

Note: Inappropriate Expedited requests may be downgraded to Standard by the Health Plan.