



Inpatient Transfer Request

Use this form to request and manage transfers from one inpatient facility to another inpatient facility (including sub acute).

Email Completed Form to the BUHPBHUMPAMailbox@bannerhealth.com

This request is to be typed

Date:

Reason for request: Administrative or Clinical

Member Name:

AHCCCS ID #

Date of Admit to Current Facility:

Name of Current Facility:

Name/Phone & Email of Person Making this Request:

Date of Requested Transfer:

Name of Facility Member will Transfer to:

Address of Transfer Location:

Contact Name/Number at Transfer Location who can verify member's acceptance?

Reason Member Needs to be Transferred:

If the request is for ECT, provide date PA for ECT was submitted:

Email this form to your current Banner reviewer. Be prepared to provide any additional clinical or administrative information needed for consideration.

Please note, a transfer for IMD may not be necessary.

A determination will be made within 2 business days of receipt.