

Behavioral Health Prior Authorization Form

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

**** Fax Completed form to:**

Fax: (520) 694-0599

Today's Date: _____

Health Plan:

- Banner – Complete Care (ACC)
- Banner - University Family Care (ALTCS)
- Banner - Advantage (Medicare)

Requesting Provider Name & Type:

Address: _____

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

Phone: _____

NPI ID: _____

Tax ID: _____

Direct Contact/Backline for Requesting Provider:

Backline #: _____

Fax #: _____

Email Address: _____

Standard (up to 14 days for approval)

Expedited (up to 72 hours for approval)

*Expedited authorization may be requested when the provider determines that using the standard time frame could **seriously jeopardize the member's life and/or health or ability to attain, maintain or regain maximum function.**

Place of Service: (If facility info is not noted above)

Facility Information

Name: _____

Address: _____

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

Phone: _____

NPI ID: _____

Tax ID: _____

Member Name Last: _____

Member Name: First: _____

Date of Birth: _____

AHCCCS ID#: _____

(Which specialty provider are you referring the member to)

Name of the Specialist to:

Specialty Type: _____

Address: _____

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

NPI #: _____

Tax ID #: _____

Out Of Network 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: _____

Comments:
