Banner
University Health Plans

Today's Date: _____

Medical Prior Authorization Form

ALL fields on this form are required for processing this request, if incomplete, will be returned.
Please attach ALL pertinent clinical information with your submission.
Fax completed form to: (520) 874-3418 or (866) 210-0512 ***(Please only submit to one fax number.)***

Submission Type: ☐ AHCCCS ☐ Medicare

Health Plan: ☐ Banner – University Family Care/ACC ☐ Banner – University Family Care/ALTCS ☐ Banner Medicare Advantage Dual

Member Name: Last _____ First _____ MI _____

Member Date of Birth: _____ Member ID#: _____

Provider making this request (Name & Provider Type):

_____

Address: _____

City: _____ State: _____ Zip: _____

NPI: _____ TID: _____

Phone #: _____

☐ In-Network ☐ Out-of-Network

*Name/Direct Contact (Requesting Provider office):

_____

Backline #: _____ Ext: _____

Fax #: _____

Office Email: _____

☐ Outpatient ☐ Inpatient ☐ Office ☐ Home

Facility Information (Outpatient/Inpatient Only):

Name: _____

City: _____ State: _____ Zip: _____

Phone #: _____

NPI: _____ TID: _____

Provider and/or Facility to perform the request:

_____

Specialty Type: _____

Address: _____

City: _____ State: _____ Zip: _____

NPI: _____ TID: _____

Out-of-Network Provider/Facility: ☐ Yes ☐ No

All Out-of-Network provider/facility, provide reason:

Procedure Requested:

Description: _____

Date of Procedure (if sched): _____

HCPC/CPT Code: _____

HCPC/CPT Code: _____

ICD-10 Code: _____

ICD-10 Code: _____

Expedite - defined as member's life, health or ability to regain maximum function is in serious jeopardy if determination is not made in the standard timeframe. **Request must include supporting documentation to substantiate an expedited review.**

Explanation Required:

Comments: