Banner University Health Plans

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

Today's Date: _____

Submission Type:
- ❑ AHCCCS
- ❑ Medicare

Health Plan:
- ❑ Banner – University Family Care/ACC
- ❑ Banner – University Family Care/ALTCS
- ❑ Banner – University Care Advantage (HMO SNP)

Member Name: Last_____ First_____ MI____

Date of Birth: _____ **Member ID#:** _____

Provider making this request (Name & Provider Type)

_____

Address: _____

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

NPI: _____ **& TID**_____

PHONE #: _____

***Name of Direct Contact (from Requesting Provider office):**

_____

Backline #: _____ **Ext:** _____

Fax #: _____

Request Priority: ❑ Standard ❑ Expedited

- Standard - Up to 14 days for approval
- Expedited* - Up to 72 hours for approval

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

❑ Outpatient ❑ Inpatient ❑ Office ❑ Home

Facility Information (Outpatient/Inpatient Only)

Name: _____

Address: _____

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

Phone: _____

NPI: _____ **& TID:** _____

Provider &/or Facility to perform the request:

_____

Specialty Type: _____

Address: _____

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

NPI: _____ **& TID:** _____

OON Provider: ❑ Yes ❑ No

Procedure Requested:

Description: _____

Date of Procedure (if sched): _____

HCPC/CPT Code: _____

HCPC/CPT Code: _____

ICD-10 Code: _____

ICD-10 Code: _____

Comments:

SAVE PRINT