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:
- ☐ New Request
- ☐ Resubmission (AHCCCS)
- ☐ Submission Reconsideration (Medicare)

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

Member Name: **Last**_____ **First**_____ **MI**____

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

Requesting Provider Name & Type

_____

Address: _____

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

NPI: _____**& TID**_____

PHONE #: _____

***Direct Contact:** _____

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.

Note: Inappropriate Expedited requests may be downgraded to a Standard request by UAHP/BUHP.

First and last name of the specialist consult to:

_____

Specialty Type: _____

Address: _____

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

NPI: _____ **& TID:** _____

OON Provider: ❑ Yes ❑ No

Procedure Requesting:

_____

Date of Procedure: _____

HCPC/CPT Code: _____

HCPC/CPT Code: _____

ICD-10 Code: _____

ICD-10 Code: _____

Place of Service: _____

Facility Information (Outpatient/Inpatient Only)

Name: _____

Address: _____

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

Phone: _____

NPI: _____ **& TID:** _____

Comments: