Arizona Priority Care

Prior Authorization Request Form

ALL FIELDS ARE REQUIRED. Please fill out the form in its entirety.
Any fields left blank may result in a delay or a denial of the request.
FAX: 480-499-8798 / 855-711-2915

Requesting Contact Name:	Requesting Contact Phone Number:	Fax Number:
Ordering Provider Name:	Ordering Provider Tax ID#:	

The following records MUST be submitted with this request :

☐ Nurses Notes ☐ Medical Records

PATIENT DATA

Patient Name:	Patient Phone Number:	
Patient Address:	City:	Zip code:
Patient Insurance ID:	Date of Birth	

REQUEST DATA

Procedure or Treatment Requested/Date of Service

☐ OUTPATIENT ☐ INPATIENT ☐ OFFICE _____ # of Visits Requested

Requesting Provider:	Facility to provide service:
Diagnosis code (ICD-9):	Facility Tax ID#:

Procedure codes (CPT's) -When using J-or HCPCS- Codes specify # of units:

All prior authorization requests will be processed as routine unless there has been documented communication between your Physician Provider and an Arizona Priority Care Medical Director. To speak with an Arizona Priority Care Medical Director call **(480) 499-8735.**
Please enter the name of the Medical Director spoken with: _____

*** Please note Medicare's definition of a STAT request is as follows: "The standard review timeframe may seriously jeopardize the life or health of the Member, or the Member's ability to regain maximum function***

PRIOR APPROVAL IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER.

Payment is authorized only for the medical services noted above, and is subject to the limitations and exclusions as outlined in the Member's Evidence of Coverage. This decision may be appealed through the health plan's grievance procedure as outlined in the members Evidence of Coverage.

Mail to: Arizona Priority Care Attn: Prior-Authorization Department, 6165 West Detroit Street, Chandler, AZ 85226
PHONE: (480) 499 - 8730 / (855) 711 - 2914

Form # QPA0001 Rev. 1.2 02/19/2014