Arizona Priority Care™

One Goal. One Priority. Your Healthcare.

Follow-up Request for Treatment Authorization

This information will be shared with the patient's primary care physician.

Patient: _____ Date: _____

Patient DOB: _____ Patient's Phone #: _____

Provider/Facility: _____ Provider/Facility Phone #: _____

Provider Address_____

Reason for Referral/Chief Complaint: _____

Changes to Present Illness: _____

_____

_____

Frequency/Severity of current symptoms: _____

Current medications: _____

ICD-10 Diagnosis:

_____ _____

_____ _____

Treatment Recommendations: _____

_____

_____

_____

Requested Treatment _____

Frequency: _____ times per _____

☐ I certify that the above is true and correct. The treatment plan has been reviewed and agreed upon by the patient.

Provider's Signature: _____ Date: _____

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