Arizona Priority Care™

One Goal. One Priority. Your Healthcare.

Initial 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: _____

Description of Present Illness: _____

Frequency/Severity of current symptoms: _____

Psychiatric History: _____

Current Medications: _____

Known Allergies: _____

Current/Past Substance Abuse: _____

ICD-10 Diagnosis/Description:

_____ _____

_____ _____

Treatment Recommendations: _____

_____

_____

Requested Treatment: _____

Frequency: _____ **times per** _____ **Next scheduled visit (date):** _____

☐ I certify that the above is true and correct.

Provider's Signature: _____ Date: _____

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