Arizona Priority Care™
One Goal. One Priority. Your Healthcare.

Prior Authorization Request Form
Fax Request and Supporting Documentation to: (480) 499-8798

☐ Standard – up to 14 calendar days for processing.

☐ Expedited** – up to 72 hours for processing.

****Must meet one of the following to qualify for expedited review:**
*(**1**) the member's life, health, or ability to regain maximum function is in serious jeopardy; (**2**) the life, health, and safety of the member or others is in jeopardy due to the member's psychological state; or*
*(**3**) the standard turnaround time would subject the member to adverse health consequences without the care or treatment being requested.*

****Rationale for requesting an expedited review:** _____

_____

_____

Request Date**:** _____ Anticipated Date of Service: _____

Member's Name: _____ DOB: _____

Mailing Address: _____ City: _____ Zip Code: _____

Phone: _____ Member ID#: _____

Requesting Provider: _____

Tax ID/NPI: _____ Fax: _____

Contact Name: _____ Phone w/extension: _____

Referred To Provider: _____

Tax ID/NPI: _____ Specialty Type: _____

Phone: _____ Fax: _____

Facility: _____ Tax ID/NPI: _____

Place of Service: ☐ In Office ☐ Home ☐ Inpatient ☐ Outpatient ☐ ASC

ICD-10 Code(s): _____

CPT/HCPCS: _____ Quantity: _____ CPT/HCPCS Code: _____ Quantity: _____

CPT/HCPCS: _____ Quantity: _____ CPT/HCPCS Code: _____ Quantity: _____

CPT/HCPCS: _____ Quantity: _____ CPT/HCPCS Code: _____ Quantity: _____

***For Part B drug requests ONLY**, please use the Part B Drug Prior Auth form located on our website.*
http://azprioritycare.com/for-providers/forms-and-reference-materials/

***For Part D drug requests**, please submit your request to the member's health plan.*