



FEE-FOR-SERVICE AUTHORIZATION REQUEST FORM

(One Member and Provider Per Form. Per Fax Please)

◆ **Mandatory Fields must be completed or information will be returned.**



AHCCCS does not require authorization when Medicare or other insurance is primary.

◆ TYPE OF ACUTE SERVICE REQUESTED

Prior Authorization		
<input type="checkbox"/> Acute Medical I/P MR# _____	<input type="checkbox"/> DME	<input type="checkbox"/> Lodging/Meals
<input type="checkbox"/> Acute Medical O/P MR# _____	<input type="checkbox"/> Home Health	
<input type="checkbox"/> Surgical Request	<input type="checkbox"/> Home Infusion	
LTC Acute	BH Level I - IP Facilities	Tribal ALTCS
<input type="checkbox"/> NF	<input type="checkbox"/> GR	<input type="checkbox"/> DME
<input type="checkbox"/> Hospice	<input type="checkbox"/> PY TRBHA	<input type="checkbox"/> Home Modification
	<input type="checkbox"/> NN TRBHA	<input type="checkbox"/> NF (Special Rates)
Transportation	<input type="checkbox"/> WM TRBHA	<input type="checkbox"/> Assisted Living-Behavioral Health
<input type="checkbox"/> Medical NEMT	<input type="checkbox"/> Other	
<input type="checkbox"/> Behavioral Health NEMT		<input type="checkbox"/> Dental

◆ RECIPIENT NAME: _____	◆ AHCCCS ID (9 digits):	A <input type="text"/>
◆ PROVIDER NAME: _____	◆ PROVIDER NPI: (10 digits)	<input type="text"/>
◆ PROVIDER PHONE#: _____	◆ AHCCCS ID: (6 digits)	<input type="text"/>
◆ PROVIDER FAX #: _____	◆ DATES OF SERVICE: _____	
◆ DIAGNOSIS: _____ (BH NEMT: Use valid BH diagnosis)		
*CPT/HCPCS/ _____	Modifier: _____	Units: _____
CDT/ _____		Tiers: <input type="checkbox"/> ICU Date: _____
REV Code _____		<input type="checkbox"/> Routine _____
_____		_____
_____		_____
_____		_____
*If CPT/HCPCS are BR (Non-Capped) price is needed (Code/Price): _____		
TRANSPORT: _____	TRIP COUNT: _____	TRIP FROM : _____
	(One Way=1 Round Trip=2)	TRIP TO _____
REASON FOR TRIP: _____		
COMMENTS: _____		
