# Prior Authorization Request for

# HEALTHCARE SERVICES

An Independent Licensee of the Blue Cross Blue Shield Association

(* = Required Field)

## 1 — SUBMISSION INFORMATION

| Name | Phone | Fax | Date |
|---|---|---|---|
| | | | / / |

## 2 — REASON FOR REQUEST

| Review Type* | Clinical Reason for Urgency |
|---|---|
| ☐ Non-Urgent ☐ Urgent | |
| **Request Type** | **Previous Authorization Number** |
| ☐ Initial ☐ Extension/Renewal/Amendment | |

## 3 — EXPEDITED/URGENT REVIEW

☐ **Expedited/Urgent Review Requested -** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

| Signature of Prescriber or Prescriber's Designee |
|---|
| /s/ |

## 4 — PATIENT INFORMATION

| Name* | Phone* | DOB* | Gender* |
|---|---|---|---|
| | | / / | ☐ M ☐ F |

| Member Name (if different from above) | Member ID #* | Group Name or Number |
|---|---|---|
| | | |

## 5 — PROVIDER INFORMATION

| **Requesting Provider or Facility** | | **Service Provider or Facility** | | |
|---|---|---|---|---|
| Provider/Facility Name* | | Provider/Facility Name* | | |
| | | | | |
| NPI #* | Specialty* | NPI #* | Specialty* | |
| | | | | |
| Phone* | Fax* | Phone* | Fax* | |
| | | | | |
| Contact Name* | Phone* | Service Care Provider's Name | Phone | Fax |
| | | | | |

## 6 — SERVICES REQUESTED* (with CPT, CDT, or HCPCS code) and supporting diagnosis (with ICD code)

| Planned Service/Procedure | Code | Start Date | End Date | Diagnosis Description (include ICD version) | Code |
|---|---|---|---|---|---|
| | | / / | / / | | |
| | | / / | / / | | |
| | | / / | / / | | |
| | | / / | / / | | |

| | | | |
|---|---|---|---|
| ☐ Inpatient | ☐ Outpatient | ☐ Provider Office | ☐ Observation |
| ☐ Home | ☐ Day Surgery | ☐ Other | |

| ☐ Physical Therapy | ☐ Occupational Therapy | ☐ Speech Therapy | ☐ Cardiac Rehab | ☐ Mental Health/Substance Abuse |
|---|---|---|---|---|
| Number of Sessions | Duration | Frequency | Other | |
| | | | | |

| ☐ Home Health | Order Attached? ☐ Yes ☐ No | | Nursing Assessment Attached? ☐ Yes ☐ No |
|---|---|---|---|
| Number of Visits | Duration | Frequency | Other |
| | | | |

| **7 — CLINICAL DOCUMENTATION** (attach clinical documentation as needed) |
|---|
| Comments/Notes |

**SAVE and fax this form to BCBSAZ at 1-844-263-2272.**

**If you have questions, call us at 602-864-4320 or 1-800-232-2345.**

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