BCBSAZ MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST
FAX FORM (for BCBSAZ Medicare Advantage plans)

An Independent Licensee of the Blue Cross Blue Shield Association

For BCBSAZ-administered plans, request prior authorization from eviCore for medical oncology, radiation therapy, high-tech radiology, genetic testing, spine/joint surgeries, and interventional pain management services (use the online request tool at eviCore.com). For all other services, fax this form and clinical records to BCBSAZ at the applicable number below.

Select the plan administrator below (as displayed on the back of the member ID card) and fax this form and clinical records to the appropriate fax number.

☐	**BCBSAZ**	Standard requests–fax to **602-544-5652**	Post-acute care, behavioral health, and concurrent reviews–fax to **602-544-5654**
		Expedited requests–fax to **602-544-5651**	Part B drugs–fax to **602-544-5622**
		Inpatient notifications–fax to **602-544-5653**	After-hours phone number for immediate services–call **1-800-446-8331**

☐	**P3 Health Partners**	All medical services requests, Part B drugs, and inpatient notifications–fax to **520-274-4943** (or online at P3portal.P3hp.org)
		After-hours phone number for immediate services–call **520-274-4421**

☐	**AZPC**	Services, items, and Part B drugs–fax to **480-499-8798** (or online at AZconnect)
		Inpatient notifications/concurrent review–fax to **480-499-8779**
		After-hours phone number for immediate services–call **480-499-8700**

1. DATE AND TYPE OF REQUEST (MM/DD/YYYY) / /

TYPE OF REQUEST		
☐	Notification	Urgent/emergency inpatient admission
☐	Prior Auth–Standard	Elective admission or services to be scheduled within 30 days (prior authorization date ranges may vary)
☐	Prior Auth–Expedited	Provider certifies that applying the standard review time frame may seriously jeopardize the member's life, health, or ability to recover, or result in serious impairment or permanent disability
☐	Prior Auth–Part B Drug	Drugs covered under medical benefits and usually administered by a healthcare professional
☐	Prior Auth–Post-Acute Care	Transition to non-acute care setting (SNF, EAR, LTAC, home health); projected date of transition (mm/dd/yyyy) / /
☐	Concurrent Review	Submission of clinical documentation for ongoing acute or post-acute care

2. MEMBER/PATIENT INFORMATION

Patient/Member Name (First)		Last	MI
Phone Number	Patient DOB (mm/dd/yyyy) / /	Member ID # (including prefix)	

3. ORDERING PROVIDER

Provider Name	TIN	Specialty	Contact Name	Phone
	NPI#			Fax
Group Name		Group Address		
City, State, ZIP		Phone	Fax	

4. SERVICING PROVIDER

Provider Name	TIN	Specialty	Contact Name	Phone
	NPI#			Fax
Is servicing provider in-network for this member's benefit plan? ☐ Yes ☐ No				
Group/Facility Name (if different from above)	TIN	Address		
	NPI#			
City, State, ZIP		Phone	Fax	

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5. PLACE OF SERVICE (if applicable)

Place of Service: ☐ Office ☐ Outpatient ☐ Inpatient ☐ Home ☐ *Other
*Please specify if other:

6. CODING

ICD-10 Code(s):		ICD-10 Descriptions:	
HCPCS/CPT/CDT Code	**Code Description**	**Units**	**Frequency Requested**

7. ADDITIONAL TYPES OF SERVICE NEEDED

Type of Service:		Name of Therapy/Agency:
Units/Visits Requested:	Frequency/Length of Time Needed:	☐ Initial ☐ Extension Prior Authorization #:
Additional Comments:		

8. MEDICATION(S) (covered under medical benefits)

Diagnosis name and code:

Medication Requested	**Strength**	**Dosing Schedule**	**Quantity/Frequency**

Is the patient currently treated with requested medication(s): ☐ Yes ☐ No If yes, when was treatment with the requested medication started? / /

Explain the medical reason for requested medication, including an explanation for selecting this medication over alternatives:

List any other medications the patient will use in combination with requested medication:

9. CLINICAL DOCUMENTATION

Please attach required documentation for medical necessity evidence and concurrent reviews, including relevant patient history and physical, physician consult notes, lab data, imaging and procedure reports, progress notes, discharge summary (if available), recent PT/OT evaluations, or other relevant information (e.g., change in condition/status). Requests submitted without appropriate clinical documentation may be denied. Comments:

SAVE and FAX this form, along with clinical records documenting evidence of medical necessity, to BCBSAZ, P3 Health Partners, or AZPC at the fax numbers listed on the top of page 1.