

Prior Authorization Request for HEALTHCARE SERVICES



An Independent Licensee of the Blue Cross Blue Shield Association

Attention Gold Card Program Providers:

Please call the Gold Card Hotline at **602-864-4811** for your authorization number.

(* = Required Field)

1 – SUBMISSION INFORMATION			
Name	Phone	Fax	Date
			/ /

2 – REASON FOR REQUEST	
Review Type*	Clinical Reason for Urgency
<input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	
Request Type	Previous Authorization Number
<input type="checkbox"/> Initial <input type="checkbox"/> Extension/Renewal/Amendment	

3 – EXPEDITED/URGENT REVIEW
<input type="checkbox"/> 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*
		/ /	<input type="checkbox"/> M <input type="checkbox"/> 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
		/ /	/ /		
		/ /	/ /		
		/ /	/ /		
		/ /	/ /		

<input type="checkbox"/> Inpatient	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Provider Office	<input type="checkbox"/> Observation
<input type="checkbox"/> Home	<input type="checkbox"/> Day Surgery	<input type="checkbox"/> Other	

<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Cardiac Rehab	<input type="checkbox"/> Mental Health/Substance Abuse
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Number of Sessions	Duration	Frequency	Other

<input type="checkbox"/> Home Health	Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Nursing Assessment Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Number of Visits	Duration	Frequency	Other

7 – CLINICAL DOCUMENTATION (attach clinical documentation as needed)

Comments/Notes

SAVE and fax this form to AZ Blue at 1-844-263-2272.
If you have questions, call us at 602-864-4320 or 1-800-232-2345.

