

PRIOR AUTHORIZATION CORRECTION FORM

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

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

♦ **AHCCCS does not require an authorization when primary insurance pays for service.**

♦ TYPE OF ACUTE SERVICE REQUESTED		
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Prior Authorization</p> <p><input type="checkbox"/> Acute Medical I/P MR# _____</p> <p><input type="checkbox"/> Acute Medical O/P MR# _____</p> <p><input type="checkbox"/> Surgical Request</p> </div> <div style="width: 45%;"> <p><input type="checkbox"/> DME <input type="checkbox"/> Lodging/Meals</p> <p><input type="checkbox"/> Home Health</p> <p><input type="checkbox"/> Home Infusion</p> </div> </div>		
<p>LTC Acute</p> <p><input type="checkbox"/> NF</p> <p><input type="checkbox"/> Hospice</p>	<p>Behavioral Health IP Level I</p> <p><input type="checkbox"/> GR</p> <p><input type="checkbox"/> PY TRBHA</p> <p><input type="checkbox"/> NN TRBHA</p> <p><input type="checkbox"/> WM TRBHA</p> <p><input type="checkbox"/> Other</p>	<p>Tribal ALTCS</p> <p><input type="checkbox"/> DME</p> <p><input type="checkbox"/> Home Modification</p> <p><input type="checkbox"/> NF (Special Rates)</p> <p><input type="checkbox"/> Assisted Living-Behavioral Health</p> <p><input type="checkbox"/> Open Line Request</p>
<p>Transportation</p> <p><input type="checkbox"/> Medical NEMT</p> <p><input type="checkbox"/> Behavioral Health NEMT</p>	<p><input type="checkbox"/> Dental</p>	

♦ RECIPIENT NAME: _____	♦ AHCCCS ID (9 digits): <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;">A</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>	A														
A																
♦ PROVIDER NAME: _____	♦ PRIOR AUTHORIZATION #: _____															
♦ PROVIDER PHONE #: _____	♦ PROVIDER NPI: (10 digits) <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>															
♦ PROVIDER FAX #: _____	♦ AHCCCS ID: (6 digits) <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>															
♦ DIAGNOSIS: _____ (BH NEMT: use valid BH diagnosis)	♦ DATES OF SERVICE: _____															
<p>A=ADD R=REMOVE</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;"><input type="checkbox"/> A</td> <td style="width: 30%; border: none;"><input type="checkbox"/> R</td> <td style="width: 30%; border: none;">Tiers: <input type="checkbox"/> ICU</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> A</td> <td style="border: none;"><input type="checkbox"/> R</td> <td style="border: none;"><input type="checkbox"/> Routine</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> A</td> <td style="border: none;"><input type="checkbox"/> R</td> <td></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> A</td> <td style="border: none;"><input type="checkbox"/> R</td> <td></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> A</td> <td style="border: none;"><input type="checkbox"/> R</td> <td></td> </tr> </table>		<input type="checkbox"/> A	<input type="checkbox"/> R	Tiers: <input type="checkbox"/> ICU	<input type="checkbox"/> A	<input type="checkbox"/> R	<input type="checkbox"/> Routine	<input type="checkbox"/> A	<input type="checkbox"/> R		<input type="checkbox"/> A	<input type="checkbox"/> R		<input type="checkbox"/> A	<input type="checkbox"/> R	
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*CPT/HCPCS/ _____ Modifier: _____ Units: _____																
CDT/ _____																
REV Code _____																
*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: _____															
COMMENTS: _____																