



## PRIOR AUTHORIZATION CORRECTION FORM

(One Member Per Form Please)

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

*Type of change requested*

◆ TYPE OF ACUTE SERVICE REQUESTED		
<input type="checkbox"/> <b>Prior Authorization</b> <input type="checkbox"/> Acute Medical I/P MR# _____ <input type="checkbox"/> Acute Medical O/P MR# _____ <input type="checkbox"/> Surgical Request	<input type="checkbox"/> <b>LTC Acute</b> <input type="checkbox"/> NF <input type="checkbox"/> I/P Therapy  <input type="checkbox"/> <b>Transportation</b>  <input type="checkbox"/> <b>Dental</b>	<input type="checkbox"/> <b>Behavioral Health</b> <input type="checkbox"/> TRBHA <input type="checkbox"/> BHS Other  <input type="checkbox"/> <b>Tribal ALTCS</b> <input type="checkbox"/> DME <input type="checkbox"/> Home Modification <input type="checkbox"/> Above Level of Care <input type="checkbox"/> Beds <input type="checkbox"/> NF (Special Rates) <input type="checkbox"/> Assisted Living-Behavioral Health
<input type="checkbox"/> <b>DME</b> <input type="checkbox"/> <b>Therapy</b> <input type="checkbox"/> <b>Home Health</b>		

◆ RECIPIENT NAME: _____ ◆ PROVIDER NAME: _____ ◆ PROVIDER PHONE #: _____ ◆ PROVIDER FAX #: _____ ◆ DIAGNOSIS: _____ (Transportation Use R68.89)	◆ AHCCCS ID (9 digits): <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; text-align: center;">A</td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr></table> ◆ PRIOR AUTHORIZATION #: _____ ◆ PROVIDER NPI: (10 digits) <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td></tr></table> ◆ AHCCCS ID: (6 digits) (Atypical Providers Only) <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr></table> ◆ DATES OF SERVICE: _____	A																								
A																										
*CPT/HCPCS/ CDT/ REV Code _____ _____ _____ _____ _____	Modifier: _____ _____ _____ _____ _____	Units: _____ _____ _____ _____ _____	A=ADD R=REMOVE <table style="margin-left: 20px;"> <tr><td><input type="checkbox"/> A</td><td><input type="checkbox"/> R</td></tr> </table> Tiers: <input type="checkbox"/> ICU <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																									
<input type="checkbox"/> A	<input type="checkbox"/> R																									
<input type="checkbox"/> A	<input type="checkbox"/> R																									
<input type="checkbox"/> A	<input type="checkbox"/> R																									
*If CPT/HCPCS are BR (Non-Capped) price is needed (Code/Price): _____																										
TRANSPORT: _____ (One Way=1 Round Trip=2)	TRIP COUNT: _____ _____	TRIP FROM: _____ TRIP TO: _____																								
COMMENTS: _____ _____																										