**INSTRUCTIONS:** The requesting provider shall submit the request of Prior Authorization for Biomarker Testing by completing sections (A – F) of this form in its entirety and including all supporting documentation as specified in this form, and AMPM Policy 310-KK.

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| **SECTION A: TYPE OF REQUEST** | | | |
|  | **Standard request** |  | Determination within 14 calendar days from receipt of the request for the service, regardless of whether the 14th day falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona. |
|  | **Expedited Request** |  | I certify this request is urgent and medically necessary to treat an injury, illness, or condition (not life threatening) within 72 hours from receipt of the request regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona to avoid complications and unnecessary suffering or severe pain. |

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| **SECTION B: Member Information** | | | | |
|  |  |  |  |  |
| *MEMBER’S AHCCCS ID NUMBER* |  | *MEMBER’S ENROLLED HEALTH PLAN* |  | *MEMBER’S DATE OF BIRTH* |
|  |  |  |  |  |
| *MEMBER’S LAST NAME* |  | *MEMBER’S FIRST NAME* |  | *MEMBER’S INITIALS* |
|  | | | | |
| *MEMBER’S ADDRESS (if available)* | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SECTION C: PROVIDER Information** | | | | |
|  |  |  |  |  |
| *ASSESSMENT PERFORMED BY* |  | *AHCCCS PROVIDER ID* |  |  |
|  |  |  |  |  |
| *PROVIDER SPECIALTY* |  | *PROVIDER TELEPHONE NUMBER* |  | *ASSESSMENT DATE* |

|  |  |  |  |
| --- | --- | --- | --- |
| **SECTION D: TYPE of Request (include associated proprietary laboratory analyses (pla) code)** | | | |
|  |  |  |  |
|  | *BIOMARKER TEST* |  | *ASSOCIATED PLA CODE* |

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| **SECTION E: specify Member’S condition description** | |
| Member presents with (full description of current clinical condition including ICD10 codes as applicable) |  |
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| **Additionally, the Following evidence MAY BE SUBMITTED WITH THIS FORM** | |
|  | Evidence supporting the diagnosis or condition is attached. |
|  | Evidence supporting medical necessity of the test (refer to AMPM Policy 310-KK for suggested medical necessity criteria). |

|  |  |  |  |  |
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| **SECTION F: PROVIDER SIGNATURE** | | | | |
|  | | |  |  |
| *Submitting Provider Signature (Electronic)* | | |  | *Date* |
|  |  |  |  |  |
| *Printed Name* |  | *Provider Type* |  | *Contact Number* |