Banner University Health Plans
Banner – University Family Care

Behavioral Health Prior Authorization Form

Today's Date: _____
Health Plan:

☐ Banner – Complete Care (ACC)
☐ Banner – University Family Care (ALTCS)
☐ Banner – University Care Advantage (Medicare)

**** Please attach ALL pertinent clinical Information with your submission.**

**** Fax Completed form to: (520) 694-0599**

Requesting Provider Name & Type:

_____

_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

NPI ID: _____

Tax ID: _____

Direct Contact/Phone number for Requesting Provider

_____

Phone #: _____

Fax #: _____

Email Address: _____

Other email: _____

Place of Service: (If facility info is not noted above)

Facility Information
Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

NPI ID: _____

Tax ID: _____

Member Name Last: _____

Member Name First: _____

Date of Birth: _____
AHCCCS ID#: _____

If Member is a child, is member adopted? □ Yes □ No

(Which specialty provider are you referring the member to)

Name of the Specialist : _____

Specialty Type: _____

Address: _____

City: _____

State: _____ **Zip:** _____

NPI #: _____

Tax ID #: _____

Out of Network Provider: □ Yes □ No

REQUIRED:
Procedure Requesting: _____

HCPC//CPT Code/Units: _____

HCPC//CPT Code/Units: _____

HCPC//CPT Code/Units: _____

Diagnosis ICD-10 Code: _____
Diagnosis ICD-10 Code: _____

Comments:

☐ **Standard (up to 14 days for approval)**

☐ **Expedited (up to 72 hours for approval)**

*Expedited authorization may be requested when the provider determines that using the standard time frame could **seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.**

Note: Inappropriate Expedited requests may be downgraded to Standard by the Health Plan.
Further information can be found on the Behavioral Health Comprehensive Provider Manual Supplement
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