

Medical Prior Authorization Form

For all Outpatient Services and Elective Inpatient Surgery and Procedures, Fax to (866) 238-5564.
 For all Acute Urgent Admit Notifications and Post Acute (SNF/Rehab/LTAC) admissions, Fax to (520) 874-3420.

Health Plan: Banner Medicare Advantage Prime HMO Banner Medicare Advantage Plus PPO

Member Name: Last _____ First _____ MI _____

Member Date of Birth: _____ Member ID#: _____

Inpatient
 Outpatient
 Home
 Office

Provider making this request (Name & Provider Type): _____ Address: _____ City: _____ State: _____ Zip: _____ NPI: _____ TID: _____ Phone #: _____ <input type="checkbox"/> In-Network <input type="checkbox"/> Out-of-Network	Provider to perform the request (if applicable): _____ Specialty Type: _____ Address: _____ City: _____ State: _____ Zip: _____ NPI: _____ TID: _____ Continuity of Care: <input type="checkbox"/> Yes <input type="checkbox"/> No
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*Name/Direct Contact (Requesting Provider office): _____ Backline #: _____ Ext: _____ Fax #: _____ Office Email: _____	If member is currently in an active course of treatment, please enter number of months remaining and description of treatment: _____ _____
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Facility Information (Outpatient/Inpatient Only) Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____ NPI: _____ TID: _____	Procedure Requested: _____ Description: _____ Date of Procedure (if sched): _____ HCPC/CPT Code: _____ HCPC/CPT Code: _____ ICD-10 Code: _____ ICD-10 Code: _____
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Expedite - Defined as member's life, health, or ability to regain maximum function is in serious jeopardy if determination is not made in the standard timeframe. **Request must include supporting documentation to substantiate an expedited review.**

Explanation Required: