Banner Medicare Advantage

Prior Authorization Form

ALL fields on this form are required. Please attach ALL clinical information. Fax completed form to: (520) 874-3418 or (866) 210-0512 (Please only submit to one fax number)

Plan: **Banner Medicare Advantage Dual HMO D-SNP**

Member Name: Last ______________________ First ______________________ MI ________

Member Date of Birth: ______________________ Member ID# ______________________

Provider making this request (Name & Provider Type):	Provider and/or Facility to perform the request:
Address: ______________	Specialty Type: ______________
City: ________ State: ____ Zip: ____	Address: ______________
NPI: ________ TID: ________	City: ________ State: ____ Zip: ____
Phone #: ______________	NPI: ________ TID: ________
In-Network Out-of-Network	Out-of-Network Provider/Facility: Yes No
*Name/Direct Contact (Requesting Provider office):	All Out-of-Network provider/facility, provide reason:
Backline #: ________ Ext: ____	
Fax #: ______________	
Office Email: ______________	
Facility Information (Outpatient/Inpatient Only):	Procedure Requested: ______________
Outpatient Inpatient	Description: ______________
Name: ______________	Date of Procedure (if sched): ______________
Address: ______________	HCPC/CPT Code: ______________
City: ________ State: ____ Zip: ____	HCPC/CPT Code: ______________
Phone #: ______________	ICD-10 Code: ______________
NPI: ________ TID: ________	ICD-10 Code: ______________

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:

Comments:

Please attach ALL clinical information with your submission.

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