Banner Medicare Advantage

Prior Authorization Form

ALL fields on this form are required. Please attach ALL clinical information.
Fax completed form to: (866) 238-5564.

Select Plan: **Banner Medicare Advantage Prime HMO** **Banner Medicare Advantage Plus PPO**

Member Name: Last ______________________ First ______________________ MI ________

Member Date of Birth: ______________________ Member ID# ______________________

Provider making this request (Name & Provider Type): ______________________ Address: ______________________ City: __________ State: _____ Zip: _______ NPI: __________ TID: __________ Phone #: ______________________ In-Network Out-of-Network	Provider and/or Facility to perform the request: ______________________ Specialty Type: ______________________ Address: ______________________ City: __________ State: _____ Zip: _______ NPI: __________ TID: __________ Out-of-Network Provider/Facility: Yes No All Out-of-Network provider/facility, provide reason:
*Name/Direct Contact (Requesting Provider office): ______________________ Backline #: __________ Ext: _______ Fax #: ______________________ Office Email: ______________________	
Facility Information (Outpatient/Inpatient Only): Outpatient Inpatient 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: ______________________
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. Fax completed form to: (866) 238-5564.