

Request for Authorization Form



Request Type:

- Expedited** (Response required within 72 hours to avoid serious jeopardy to member's health)
- Standard** (Response required within 14 days)

NOTE: Please complete this form in its entirety. Submitting requests that are illegible, incomplete, missing clinical documentation, and/or have an inappropriate request type will increase the response turn around time.

Member Information:

Last Name	First Name	DOB	AHCCCS ID #
Address (city, state, & zip code):		Telephone #:	Primary Language
Medicare Eligibility: <input type="checkbox"/> Part A <input type="checkbox"/> Part C (provided by): _____ <input type="checkbox"/> Not Medicare Eligible <input type="checkbox"/> Part B <input type="checkbox"/> Part D (provided by): _____			
Additional Insurance Coverage			
Insurance Company Name: _____		Insured ID #: _____	
Is service being requested approved by member's primary / additional insurance?			
<input type="checkbox"/> YES: - Bridgeway does not require a prior authorization when primary insurance pays for service			
<input type="checkbox"/> NO: Please list why the service is not being covered by member's other insurance: _____			

Requesting Provider Information:

Name:	Address (city, state, & zip code):	Telephone #:
Provider Signature:	Contact Person/ext.:	FAX:

Referred to:

Full Name of the Provider/Facility:	Address (city, state, & zip code):	Telephone #:
Provider Specialty:	Anticipated Date of Service:	FAX:

Service Request:

Service Setting: Inpatient Outpatient

Service Type:

<input type="checkbox"/> Dialysis	<input type="checkbox"/> Pain Management
<input type="checkbox"/> Dental	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Home Health	<input type="checkbox"/> Office Visit
<input type="checkbox"/> Hospice	<input type="checkbox"/> Vision
<input type="checkbox"/> Imaging: _____	<input type="checkbox"/> Transplant
<input type="checkbox"/> Infusion	<input type="checkbox"/> DME
<input type="checkbox"/> Medical Supplies	Height: ____ Ft ____ In
<input type="checkbox"/> Other: _____	Weight: ____ Lbs
<input type="checkbox"/> Therapy*:	

Type	Times/Week	Number of Weeks
PT		
OT		
ST		

*Treatment plan and progress notes required

Codes & Descriptions:

ICD Code	ICD 9 Description

CPT/HCPC Code	CPT/HCPC Description

. Comments: _____