

PRIOR AUTHORIZATION

For prior authorization use 14-Day time frame: _____

TO BE COMPLETED BY REQUESTOR

Member's Name (*Last, First, M.I.*) _____

AHCCCS ID No. _____ Date of Birth _____ Date _____

Member's Address (*No., Street*) _____

City _____ State _____ ZIP Code _____

Delivery Address if Different from Mailing (*No., Street*) (*No P.O. Boxes*) _____

City _____ State _____ ZIP Code _____

Phone Number _____ Third Party Insurance _____

Policy No. _____ Phone Number _____ Medicare Yes No

Diagnosis

Cerebral Palsy Autism Cognitive/Intellectual Disability Epilepsy

Additional Diagnosis (*Specify*): _____

Diagnosis Code(s) _____ Height _____ Weight _____

Support Coordinator's Name _____

District No. _____ Phone No. _____ FAX No. _____

Medical Justification

Picture description of equipment (if applicable)

Valid prescription/Primary Care Provider's order Date Division received prescription/order: _____

Ordering Physician _____

Ordering Physician Address (*No., Street*) _____

City _____ State _____ ZIP Code _____

Phone No. _____ Vendor/Facility Name _____

Vendor Representative Name _____

Vendor Address (*No., Street*) _____

City _____ State _____ ZIP Code _____

Vendor AHCCCS ID. No. _____ Phone No. _____ FAX No. _____

TO BE COMPLETED BY VENDOR

Billing Codes _____ Modifier Code _____ Description _____ Unit(s) _____

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TO BE COMPLETED BY PRIOR AUTHORIZATION UNIT

Date Packet Received By Health Care Services _____

Approved:

Yes – Authorization Number: _____

Referred to Chief Medical Officer/Designee

No (*Requires Division's Chief Medical Officer/Designee decision*)

CRS Eligible Yes No

Approved By _____

Approved By Signature _____ Date _____

Comments

Upon approval send claims to:
Department of Economic Security
Division of Developmental Disabilities
PO Box 6123, MD 28C6
Phoenix, AZ 85005-6123

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-542-0419; TTY/TDD Services: 7-1-1.
• Free language assistance for DES services is available upon request.