ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
Health Care Services

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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See page 2 for EOE/ADA/LEP/GINA disclosures

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