

TRIBAL HEALTH PROGRAM PRIOR AUTHORIZATION REQUEST FORM

STOP
 ◇ Mandatory fields must be completed or information will be returned.
 STOP
 AHCCCS does not require authorization when Medicare or other insurance is primary.

TYPE OF SERVICE REQUESTED			
Acute Hospital Medical Inpatient Medical Outpatient Surgical Request Medical Record #			LTC Acute Nursing Facility Hospice
DME AAC Lodging/Meals Home Health Home Infusion Dental	BH Inpatient & RTC THP GR TRBHA NN TRBHA PY TRBHA WMAT TRBHA Other	BH Residential Facility THP GRTRBHA NN TRBHA PY TRBHA WMAT TRBHA Other	Transportation Behavioral Health NEMT Medical NEMT

ONE MEMBER AND PROVIDER PER FORM, PER SUBMISSION PLEASE

◇ RECIPIENT NAME:	◇ AHCCCS ID (9 digits): A
◇ PROVIDER NAME:	◇ PROVIDER NPI (10 digits):
◇ PROVIDER PHONE #:	◇ AHCCCS ID (6 digits):
◇ PROVIDER FAX #:	◇ DATES OF SERVICE:
◇ DIAGNOSIS:	<i>**For BH NEMT, use valid BH diagnosis</i>
*CPT/ HCPCS/ CDT/ REV CODE:	Modifier: Units: Tiers: ICU Date: Modifier: Units: Tiers: Routine Date: Modifier: Units: Date: Modifier: Units: Date: Modifier: Units: Date:
*If CPT/HCPCS are BR (Non-Capped) price is needed (Code/Price):	
TRANSPORT:	TRIP FROM: TRIP TO:
REASON FOR TRIP:	TRIP COUNT:

Return Fax #

THP Acute & Behavioral Health Prior Authorization: (602) 252-2298 Transportation: (602) 254-2431

**For URGENT REQUEST call us at (602) 417-4400 after submitting form to AHCCCS.
 If this form was received in error, contact the submitting Provider immediately.**