



Prior Authorization Request Form

Please refer to the P3 Health Partners Prior Authorization List
Prior Authorization for Arizona Phone: (520) 274-4421 | Fax: (520) 274-4943

Date of Request: _____

- Routine Request
- Urgent Request (for imminent or serious threat to health only)

MEMBER INFORMATION			
Planned Date of Service: _____ (recommend not scheduling until authorization is obtained)			
Member Name: <small>(First, Middle, Last)</small>		Date of Birth: <small>(MM/DD/YYYY)</small>	
Member ID:		Phone:	
SERVICING PROVIDER INFORMATION (Provider desired to render the service)			
Provider Name:		Specialty:	
Address:		Provider Group: <small>(If applicable)</small>	
NPI #:		TIN #:	
Phone:	Fax:	Network Status: <input type="checkbox"/> In Network <input type="checkbox"/> Out of Network	
Place of Service: <small>(Facility Name)</small>	Facility TIN #:	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Office	
REQUESTING PROVIDER INFORMATION (Provider requesting the service)			
Provider Name:		Provider Group: <small>(if applicable)</small>	
Contact Name:		Phone:	Fax:
NPI #:		TIN #:	
Diagnosis / ICD-10 Code(s):			
CPT / HCPCS Code(s):			
Treatment Description / Number of Units: Include clinical information, such as but not limited to number of units, test results, imaging, and duration. _____			

Please submit clinical information to support this request

Provider's Signature: _____ Date: _____

Primary Care Providers (PCPs) and Specialists should refer to contracted providers. To ensure a recommended provider is contracted, call member services:

AUTHORIZATION DOES NOT GUARANTEE PAYMENT

To view the P3 Prior Authorization list and to sign up for the P3 Provider Portal, visit: <https://p3portal.p3hp.org/EZ-NET60/Login.aspx>

FOR OFFICE USE ONLY:

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