P3 Health Partners
People. Passion. Purpose.

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: (First, Middle, Last)			Date of Birth: (MM/DD/YYYY)
Member ID:			Phone:
SERVICING PROVIDER INFORMATION (Provider desired to render the service)			
Provider Name:			Specialty:
Address:		Provider Group: (If applicable)	
NPI #:		TIN #:	
Phone:	Fax:	Network Status: ☐ In Network	☐ Out of Network
Place of Service: (Facility Name)	Facility TIN #:	☐ Inpatient	☐ Outpatient ☐ Office
REQUESTING PROVIDER INFORMATION (Provider requesting the service)			
Provider Name:		Provider Group: (if applicable)	
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: