BCBSAZ MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST
FAX FORM (for BCBSAZ Medicare Advantage plans)

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

For BCBSAZ-administered plans, request prior authorization from eviCore for medical oncology, radiation therapy, high-tech radiology, genetic testing, spine/joint surgeries, and interventional pain mangement services (use the online request tool at eviCore.com). For all other services, fax this form and clinical records to BCBSAZ at the applicable number below.

For plans administered by P3 Health Partners (check back of member ID card for plan administrator), fax this form and clinical records to **520-274-4943.**

☐	**BCBSAZ**	Standard requests - fax to: **602-544-5652**	Post-acute care, behavioral health, and concurrent reviews - fax to: **602-544-5654**
		Expedited requests - fax to: **602-544-5651**	Part B drugs - fax to: **602-544-5622**
		Inpatient notifications - fax to: **602-544-5653**	After-hours phone number for immediate services - call: **1-888-905-1172**

☐	**P3 Health Partners**	All medical services requests, Part B drugs, and inpatient notifications - fax to: **520-274-4943**
		After-hours phone number for immediate services - call: **520-274-4421**

1. TYPE OF REQUEST

☐	Prior Auth - Standard	Elective admission or services to be scheduled within 30 days (prior authorization date ranges may vary)
☐	Prior Auth - Date Certain	Elective admission or services already scheduled for this date within 30 days (mm/dd/yyyy): / /
☐	Prior Auth - Post-Acute Care	Transition to non-acute care setting (SNF, EAR, LTAC, home health); projected date of transition (mm/dd/yyyy): / /
☐	Prior Auth - Expedited	Provider certifies that applying the standard review time frame may seriously jeopardize the member's life, health, or ability to recover, or result in serious impairment or permanent disability
☐	Prior Auth - Part B Drug	Drugs covered under medical benefits and usually administered by a healthcare professional
☐	Concurrent Review	Submission of clinical documentation for ongoing acute or post-acute care

2. PATIENT INFORMATION

Patient Name (First):		Last:	MI:
Phone Number:	Patient DOB (mm/dd/yyyy): / /	Member ID # (including prefix):	

3. ORDERING PROVIDER

Provider Name:	TIN: NPI#:	Specialty:	Contact Name:
Group Name:		Group Address:	
City, State, ZIP:		Phone:	Fax:

4. SERVICING SPECIALIST/CLINIC/FACILITY PROVIDER (will provide requested service/medication/device)

Specialist Name:	TIN: NPI#:	Specialty:	Contact Name:
Is servicing provider in-network for this member's benefit plan? ☐ Yes ☐ No			
Group/Facility Name:		Address:	
City, State, ZIP:		Phone:	Fax:

5. PLACE AND TYPE OF SERVICE/ITEM/TREATMENT

Please indicate specifics about place and type of service

Place of Service: ☐ Office ☐ Outpatient ☐ Inpatient ☐ Home ☐ *Other

*Please specify if other:

Type of Service (check applicable boxes):

- ☐ Clinical trials
- ☐ Dental services
- ☐ Diagnostic testing/monitoring
- ☐ DME
- ☐ Electroconvulsive therapy (ECT)
- ☐ Extended rehab (EAR)
- ☐ Fertility services
- ☐ Genetic testing
- ☐ HIV screening
- ☐ Home health
- ☐ Hospice
- ☐ Infusion/IV therapy
- ☐ Injectable medications
- ☐ Inpatient admissions
- ☐ LTAC
- ☐ Medical oncology
- ☐ OT (cognitive skills)
- ☐ Out-of-network provider
- ☐ Outpatient surgery
- ☐ Radiation therapy
- ☐ Radiology (high-tech imaging)
- ☐ SNF
- ☐ Sleep studies
- ☐ ST (swallowing studies, spoken language comprehension)
- ☐ Transplants

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6. CODING

ICD-10 Code(s):		ICD-10 Description:	
HCPCS/CPT/CDT Code	**Code Description**	**Medical Reason**	**Frequency Requested**

7. OTHER SERVICES (requiring prior authorization, such as DME, home health, therapy)

Type of Service:		Name of Therapy/Agency:	
Units/Visits Requested:	Frequency/Length of Time Needed:	☐ Initial ☐ Extension	Prior Authorization #:
Additional Comments:			

8. MEDICATION(S) (covered under medical benefits)

Diagnosis name and code:

Medication Requested	**Strength**	**Dosing Schedule**	**Quantity/Frequency**

Is the patient currently treated with requested medication(s): ☐ Yes ☐ No If yes, when was treatment with the requested medication started? / /

Explain the medical reason for requested medication, including an explanation for selecting this medication over alternatives:

List any other medications the patient will use in combination with requested medication:

9. PREVIOUS SERVICES/THERAPY (including medication, dose, duration)

a.	Date (mm/dd/yyyy): / /
b.	Date (mm/dd/yyyy): / /
c.	Date (mm/dd/yyyy): / /
d. Reason for discontinuing previous therapy (e.g., contraindications, allergies, therapeutic failure):	

10. CLINICAL DOCUMENTATION

Please attach required documentation for medical necessity evidence and concurrent reviews, including relevant patient history and physical, physician consult notes, lab data, imaging and procedure reports, progress notes, discharge summary (if available), recent PT/OT evaluations, or other relevant information (e.g., change in condition/status).
Comments:

SAVE and FAX this form, along with clinical records documenting evidence of medical necessity, to BCBSAZ or P3 Health Partners at the fax numbers listed on the top of page 1.