Arizona Medical Prior Authorization Form

Applicable Services:

- **THERAPIES PERFORMED BY OUT-OF-NETWORK PROVIDERS**
- **GENDER AFFIRMING SERVICES**

Do not use this form: 1) to request an appeal, 2) to confirm eligibility, 3) to verify coverage, 4) to ask whether a service requires prior authorization, 5) to request prior authorization of a prescription drug, 6) for services that require precertification other than those listed above, or 7) to request a referral to an out of network physician, facility, or other health care provider.

To file via facsimile, send to**: [413-781-1958]**

To file via secure email: Set up login at wellfleet-mail.com and register for secure submittal via Zix. Send requests to: priorauth@wellfleetinsurance.com**.**

For further information or questions, please call the phone number listed on the back of the customer's ID card or call Customer Service team (800)633-7867.

PLEASE NOTE: Determination of medical necessity will be made in an expedited manner upon receipt of this form and all necessary information.
There may be a delay if additional information is needed. Wellfleet may utilize independent review organizations. *Wellfleet utilizes utilization management (UM) vendors for services that require pre-certification, separate from the "Applicable Services" noted at the top of this form. Clinical review criteria and information on how to submit pre-certification requests to UM vendors may be found https://wellfleetstudent.com/forms.

ARIZONA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I – SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:

SECTION II — REASON FOR REQUEST

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	
Request Type: ☐ Initial ☐ Extension/Renewal/Amendment	Prev. Auth. #:	

SECTION III — REVIEW

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee: _____

SECTION IV — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female
Member Name (if different from Section I):	Member ID #:	Group Name or Number:	

SECTION V — PROVDER INFORMATION

Requesting Provider or Facility		**Service Provider or Facility**	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Service Care Provider's Name:	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION VI — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other:_____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions: _____ Duration:_____ Frequency:_____ Other:_____

☐ Home Health: Order Attached? ☐ Yes ☐ No Nursing Assessment Attached? ☐ Yes ☐ No

Number of Visits: _____ Duration:_____ Frequency:_____ Other:_____

SECTION VII — CLINICAL DOCUMENTATION (Attach additional documentation as needed)

ARIZONA STANDARDIZED PRIOR AUTHORIZATION REQUEST FOR MEDICATION, DME, AND MEDICAL DEVICE

SECTION I – SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:

SECTION II — REASON FOR REQUEST

Check one:	☐ Initial Request	☐ Continuation/Renewal Request

Reason for request: (check all that apply)

☐ Step Therapy, Formulary Exception

☐ Quantity Exception

☐ Specialty Drug

☐ Prior Authorization

☐ Medical Device

☐ Durable Medical Equipment (DME)

☐ Other *(please specify)*_____

SECTION III — REVIEW

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee: _____

SECTION IV — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female	
Address:	City:		State:	ZIP Code:
Subscriber Name (if different from Section I):	Member ID #:	Group Name or Number:		
BIN # (if available):	PCN (if available):	Rx ID # (if available):		

SECTION V — PRESCRIBER/ORDERING PROVDER INFORMATION

Name:		NPI #:	Specialty:	
Address:		City:	State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

SECTION VI — PRESCRIPTION DRUG INFORMATION

(If this is a compound drug, identify all ingredients in Section VI, below.)

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

□ New therapy □ Continuation of therapy (approximate date therapy initiated:_____)

For Provider Administered Drugs Only:

HCPCS Code:_____ NDC #:_____ Dose Per Administration: _____

ARIZONA STANDARDIZED PRIOR AUTHORIZATION REQUEST FOR MEDICATION, DME, AND MEDICAL DEVICE

SECTION VII — PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name:					
Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

SECTION VIII — PRESCRIPTION DME or MEDICAL DEVICE INFORMATION

Requested DME or Medical Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):

SECTION IX — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:
Patient's diagnosis related to this request:	ICD Version:	ICD Code:

Drugs patient has taken for this diagnosis: *(Provide the following information to the best of your knowledge)*

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

SECTION X — JUSTIFICATION (Provide or attach any additional justification here: Notes, Treatment plans, lab/test results, etc)