

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



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 management services (use the online request tool at [eviCore.com](http://eviCore.com)). For all other services, fax this form and clinical records to BCBSAZ at the applicable number below.

**Select the plan administrator below** (as displayed on the back of the member ID card) and fax this form and clinical records to the appropriate fax number.

<input type="checkbox"/>	<b>BCBSAZ</b>	Standard requests—fax to <b>602-544-5652</b>	Post-acute care, behavioral health, and concurrent reviews—fax to <b>602-544-5654</b>
		Expedited requests—fax to <b>602-544-5651</b>	Part B drugs—fax to <b>602-544-5622</b>
		Inpatient notifications—fax to <b>602-544-5653</b>	After-hours phone number for immediate services—call <b>1-888-905-1172</b>
<input type="checkbox"/>	<b>P3 Health Partners</b>	All medical services requests, Part B drugs, and inpatient notifications—fax to <b>520-274-4943</b> (or online at <a href="http://P3portal.P3hp.org">P3portal.P3hp.org</a> )	
		After-hours phone number for immediate services—call <b>520-274-4421</b>	
<input type="checkbox"/>	<b>AZPC</b>	Services, items, and Part B drugs—fax to <b>480-499-8798</b> (or online at <a href="http://AZconnect">AZconnect</a> )	
		Inpatient notifications/concurrent review—fax to <b>480-499-8779</b>	
		After-hours phone number for immediate services—call <b>480-499-8700</b>	

## 1. DATE AND TYPE OF REQUEST (MM/DD/YYYY) / /

TYPE OF REQUEST		
<input type="checkbox"/>	Notification	Urgent/emergency inpatient admission
<input type="checkbox"/>	Prior Auth—Standard	Elective admission or services to be scheduled within 30 days (prior authorization date ranges may vary)
<input type="checkbox"/>	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
<input type="checkbox"/>	Prior Auth—Part B Drug	Drugs covered under medical benefits and usually administered by a healthcare professional
<input type="checkbox"/>	Prior Auth—Post-Acute Care	Transition to non-acute care setting (SNF, EAR, LTAC, home health); projected date of transition (mm/dd/yyyy) / /
<input type="checkbox"/>	Concurrent Review	Submission of clinical documentation for ongoing acute or post-acute care

## 2. MEMBER/PATIENT INFORMATION

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

## 3. ORDERING PROVIDER

<b>Provider Name</b>	TIN	Specialty	Contact Name	Phone
	NPI#			Fax
<b>Group Name</b>		Group Address		
City, State, ZIP		Phone	Fax	

## 4. SERVICING PROVIDER

<b>Provider Name</b>	TIN	Specialty	Contact Name	Phone
	NPI#			Fax
Is servicing provider in-network for this member's benefit plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Group/Facility Name</b> (if different from above)	TIN	Address		
	NPI#	Phone	Fax	
City, State, ZIP		Phone	Fax	

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**5. PLACE OF SERVICE (if applicable)**

**Place of Service:**    Office                       Outpatient                       Inpatient                       Home                       \*Other  
 \*Please specify if other:

**6. CODING**

ICD-10 Code(s):		ICD-10 Descriptions:	
HCCPS/CPT/CDT Code	Code Description	Units	Frequency Requested

**7. ADDITIONAL TYPES OF SERVICE NEEDED**

Type of Service:	Name of Therapy/Agency:		
Units/Visits Requested:	Frequency/Length of Time Needed:	<input type="checkbox"/> Initial	Prior Authorization #:
Additional Comments:		<input type="checkbox"/> Extension	

**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): <input type="checkbox"/> Yes <input type="checkbox"/> 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. 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). Requests submitted without appropriate clinical documentation may be denied. Comments:

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