Banner | aetna

Prior Authorization Form

ALL fields on this form are required. Please attach ALL clinical information.
Fax completed form to: 480.977.6116

Member Name: Last _____ First _____ MI _____

Member Date of Birth: _____ Member ID#: _____

Provider making this request (Name & Provider Type):

_____

Address: _____

City: _____ State: _____ Zip: _____

NPI: _____ TID: _____

Phone #: _____

☐ In-Network ☐ Out-of-Network

*Name/Direct Contact (Requesting Provider office):

_____

Backline #: _____ Ext: _____

Fax #: _____

Office Email: _____

Provider and/or Facility to perform the request:

_____

Specialty Type: _____

Address: _____

City: _____ State: _____ Zip: _____

NPI: _____ TID: _____

Out-of-Network Provider/Facility: ☐ Yes ☐ No

All Out-of-Network provider/facility, provide reason:

Facility Information (Outpatient/Inpatient Only):

☐ Outpatient ☐ Inpatient

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

NPI: _____ TID: _____

Procedure Requested:

Description: _____

Date of Procedure (if sched): _____

HCPC/CPT Code: _____

HCPC/CPT Code: _____

ICD-10 Code: _____

ICD-10 Code: _____

Expedite - defined as member's life, health or ability to regain maximum function is in serious jeopardy if determination is not made in the standard timeframe. **Request must include supporting documentation to substantiate an expedited review.**

Explanation Required:

Comments:

Please attach ALL clinical information with your submission. Fax completed form to: 480.977.6116