



Panel Addition Request Form
 Fax to (480) 760-4708
 Or email to msadmin@iasishealthcare.com
 Please allow up to 72 hours for processing



Date: _____ Request Made By: _____

Provider ID number: _____ Provider Name: _____

Name & Address of Facility: _____ Telephone Number: _____

_____ Fax Number: _____

AHCCCS ID NUMBER	Member's Name	Member's Date of Birth	Date of Service MM/DD/YY	For HCA/HCG Use only	
				Approved <input type="checkbox"/>	Denied <input type="checkbox"/>
				Approved <input type="checkbox"/>	Denied <input type="checkbox"/>
				Approved <input type="checkbox"/>	Denied <input type="checkbox"/>
				Approved <input type="checkbox"/>	Denied <input type="checkbox"/>
				Approved <input type="checkbox"/>	Denied <input type="checkbox"/>
				Approved <input type="checkbox"/>	Denied <input type="checkbox"/>

PCP or Office Manager Signature: _____ Date: _____

If you have any questions please contact your Network Services Representative at 1.800.322.8670

FOR HCA/HCG USE ONLY

Confirmation Sent to Provider: Yes No Date Sent: _____

Comments:

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