MEDICAL SERVICE Prior Authorization Form

► CHECK BOXES BELOW INDICATING THE CORRECT CORRESPONDING HEALTH PLAN ◄

☐ Health CHOICE

FAX
1-877-HCA-8120
(1-877-422-8120)
www.HealthChoiceAZ.com

☐ Health CHOICE HMO Generations

FAX
1-877-HCG-5680
(1-877-424-5680)
www.HCGenerations.com

►PROVIDERS ARE REQUIRED TO FILL OUT THIS FORM COMPLETELY AND SEND MEDICAL DOCUMENTATION SUPPORTING THE REQUESTED SERVICE. FAILURE TO DO SO MAY RESULT IN A DENIAL OF SERVICE◄

Member Name (Last, First)	Member ID#	DOB	Date
Requesting Provider Name	NPI#	PCP (if Different)	
Office Contact Person	DIRECT Phone #	Fax #	
Diagnosis 1 (ICD-9 code)	Diagnosis 2 (ICD-9 code)	Diagnosis 3 (ICD-9 code)	

AHCCCS* - Health Choice ARIZONA:** ☐ **Standard (Up to 14 Calendar days)** ☐ ***Expedited* **(Up to 3 Business day)**

Medicare Advantage* - Health Choice GENERATIONS HMO:** ☐ **Standard (Up to 14 Calendar days)** ☐ ***Expedited* **(Up to 72 hours)**

PLEASE NOTE: Inappropriate *EXPEDITED requests hinder the authorization process of vital medical services to Providers and Members. Inappropriate requests may be reduced to Standard by Health Choice**

Contracted Specialist (Last, First)			Specialty	
Contracted Facility to be used			Date of service	
Address	NPI#		Phone # ( )	
Name of Procedure	CPT code 1	CPT code 2	CPT code 3	CPT code 4
☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Home Health				# visits
Contracted Ancillary Service Request (DME; O&P; Equipment) and HCPCS Code (or attach list of codes)				
PLEASE NOTE - ALL IMAGING SERVICES requiring Prior Authorization should be directed to the HCA/HCG Radiology Benefits Manager **MEDSOLUTIONS** (Phone 1-888-693-3211) per the Prior Authorization Manual				

- FOR INTERNAL Health Choice USE ONLY -

Health Choice has considered the above request and has made the following medical necessity determination:

☐ **Approved:** Signature_____Date_____

☐ **Reduce Expedited ► Standard:** Medical Director/Designee_____Date_____

☐ **14-day Extension:** Medical Director/Designee _____Date_____
Requested documentation:

☐ **Denied:** Medical Director/Designee _____Date_____
- ❑ Insufficient medical documentation was received by HCA/HCG in order to make a medical necessity determination.
- ❑ There is no documentation of medical necessity based on the documentation received for review by HCA/HCG.
- ❑ There is no documentation of trial/failure of conservative medical treatment(s) by the requesting provider.
- ❑ Documentation received does not support the medical necessity to use a non-contracted HCA/HCG provider/facility.
- ❑ The requested service is not a covered plan benefit.

Provider Notice: