

## UPDATES TO THE TREATMENT AUTHORIZATION REQUEST FORM

June 25, 2015

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Dear Care1st and ONECare Providers and Staff:

We have updated our Treatment Authorization Request (TAR) form. The following fields have been added. Collecting these additional, important pieces of information allows us to process your requests by reducing additional outreach to you.

- Anticipated DOS
- Group/Practice Affiliation
- FQHC Location (yes/no)

Make certain your request is checked “Routine” or “Urgent” as medically appropriate and include the relevant medical documentation to support the request. This will result in faster turnaround for all authorization requests.

The Treatment Authorization Request form is also available at [www.care1st.com/az](http://www.care1st.com/az) in the following location:

Care1st > Providers > Forms > select Medical Prior Authorization Form

Please download and distribute for use immediately, and don’t hesitate to call Provider Network Operations with any questions.

***Thank you!***



**Treatment Authorization Request**  
Ph 602.778.1800 (Options 5, 6) Fax 602.778.1838



AHCCCS

DDD

ONECare

Routine

Urgent [May seriously jeopardize member's life, health or function level]

Retroactive

**Patient Information**

Member Name:		Date of Birth:	
Member Address (Street):			
Member Address (City, State, Zip):			Male <input type="checkbox"/> Female <input type="checkbox"/>
Member ID:			
Requesting Physician's Name: (PLEASE PRINT)		Group/Practice Affiliation:	
Office Contact Name:	Phone:	Fax:	

**Service Information**

Referred To:		Group/Practice Affiliation:	
Date of Request:	Anticipated Date of Service:	Specialty:	
Provider Address:			
Phone:	Fax:	FQHC Location?: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Comments:			
Hospital Name:		Other:	

**Service(s) Requested**

<input type="checkbox"/> Hospital Admit Anticipated LOS:	<input type="checkbox"/> Hospital Outpatient	<input type="checkbox"/> ASC	<input type="checkbox"/> In-Office Proc/Testing	<input type="checkbox"/> Consult Only	<input type="checkbox"/> Follow-up Visits (Attach Relevant Data, Notes, Tests, Etc.)	<input type="checkbox"/> Health Education
Requested Service/Procedure:				CPT 4 Code(s):	Unit(s):	
Diagnosis Description:				Diagnosis Code(s) :		

**Submission of appropriate documentation with your initial request will expedite processing of your request.**

Please include:  Office Notes       X-ray Reports       Other Diagnostic Tests  
 Lab Results       Specialist Consult Notes

**Authorization for specialist office visits are valid 90 days for a consultation and 2 follow up visits unless otherwise noted.**

Comments:

**AUTHORIZATION DOES NOT GUARANTEE PAYMENT.** Authorization is subject to member eligibility and benefit coverage on date of service. If the member is determined to be ineligible on the date of service, does not have benefit coverage for the service or has exceeded benefit limits, the member may be responsible for the service. To ensure proper payment for services rendered, the provider/facility must verify eligibility or benefits on the date of service. Payment will not be made for unauthorized services. All services must be ordered/ performed by contracted providers unless an out of network authorization is obtained. Please send specialist findings to the PCP. This authorization is good for 90 days unless otherwise noted.