



MARICOPA
CARE ADVANTAGE

managed by



UNIVERSITY PHYSICIANS HEALTH PLANS
PRIOR AUTHORIZATION FORM



ALL SECTIONS OF THIS FORM MUST BE COMPLETED &
MEDICAL DOCUMENTATION MUST BE PROVIDED

Visit our Web site at www.uph.org to view the current formulary, to verify eligibility and much more...

FAX: (520) 874-3418 or (866) 210-0512

Date: _____

Requesting Provider: _____

PCP (if different): _____

Office PA Contact:
Phone#: _____
Fax #: _____

PRIORITY Mark One:
 Standard (up to 14 days for approval)
 Expedited* (up to 72 hours for approval)
* Providers must use "Expedited" *only* when medically necessary!
Please Note: Inappropriate Expedited requests may be down graded to Standard by UPHP

Member Name _____
Date of Birth _____
UPHP ID# _____

Specialist Consult To: _____
Specialist Location: _____
Name of Procedure(s): _____
Contracted facility to be used: _____
Date Scheduled (if known): _____
Ancillary Service Request: _____
 Physical Therapy Occupational Therapy Speech Therapy
Number Visits _____ / _____
Diagnosis/ICD-9 code _____ / _____
Diagnosis/ICD-9 code _____ / _____
Diagnosis/CPT code _____ / _____

COMMENTS:

Response to Provider: UPHP has considered the above request and has made the following determination:

Approved

Denied for the Following Reason(s): # _____

1. Requested service is not an AHCCCS covered benefit.
2. No notes were received with the request by UPHP in order to evaluate for medical necessity.
3. No documentation of medical necessity based on the information received for review by UPHP.
4. No documentation of trial / failure of conservative medical treatment(s) by the referring provider.

Denial letter type: _____

Medical Director Signature: _____ Date of Decision: _____

Comments: _____