CARE 1ST HEALTH PLAN ARIZONA
A WellCare Company

ONECARE
A WellCare Company

Treatment Authorization Request

***OutPt Services /Residential(BH)* : Ph 602.778.1800 (Options 5, 6) Fax 602.778.1838**
***For Admissions/SNF send Facesheet to*: Fax 602.778.8386**

☐ **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 ☐ Female ☐
Member ID:		
Requesting Physician's Name: (PLEAST PRINT)	TIN/NPI:	
Office Contact Name:	Phone:	Fax:

Service Information

Referred To:	TIN/NPI:	
Date of Request:	**Anticipated Date of Service**:	Specialty:
Provider Address:		
Phone:	Fax:	FQHC Location?: Yes ☐ No ☐ MSIC Location? Yes ☐ No ☐
Hospital Name:	Other:	

Service(s) Requested

☐ Hospital Admit Date of Admit:	☐ Hospital Outpatient	☐ ASC	☐ In-Office Proc/Testing	☐ OP Consult Only	☐ Follow-up Visits (Attach Relevant Data, Notes, Tests, Etc.)	☐ OP BH Services
☐ BH Residential	☐ OOS Provider	☐ Home	☐ Other			

Requested Service/Procedure:	CPT 4/HCPCS 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/Prog. Notes/Assess./Eval** ☐ **X-ray Reports** ☐ **Other Diagnostic Tests**
☐ **Lab Results** ☐ **Specialist Consult Notes** ☐ **ASAM/CASII**

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. 10/1/18