

Request for Authorization Form



by Bridgeway Health Solutions HMO SNP

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Telephone: (866) 295-9729
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Request Type:

- Expedited** (Response required within 72 hours to avoid serious jeopardy to member's health)
- Standard** (Response required within 14 days)

NOTE: Please complete this form in its entirety. Submitting requests that are illegible, incomplete, missing clinical documentation, and/or have an inappropriate request type will increase the response turn around time.

Member Information:

| | | | |
|---|------------|---------------------|------------------|
| Last Name | First Name | DOB | AHCCCS ID # |
| Address (city, state, & zip code): | | Telephone #: | Primary Language |
| Additional Insurance Coverage | | | |
| Insurance Company Name: _____ | | Insured ID #: _____ | |
| Is service being requested approved by member's primary / additional insurance? | | | |
| <input type="checkbox"/> YES: - Bridgeway does not require a prior authorization when primary insurance pays for service | | | |
| <input type="checkbox"/> NO: Please list why the service is not being covered by member's other insurance: _____ | | | |

Requesting Provider Information:

| | | |
|---------------------|------------------------------------|--------------|
| Name: | Address (city, state, & zip code): | Telephone #: |
| Provider Signature: | Contact Person/ext.: | FAX: |

Referred to:

| | | |
|-------------------------------------|------------------------------------|--------------|
| Full Name of the Provider/Facility: | Address (city, state, & zip code): | Telephone #: |
| Provider Specialty: | Anticipated Date of Service: | FAX: |

Service Request:

Service Setting: Inpatient Outpatient

Service Type:

| | |
|---|--|
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Office Visit |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Imaging: _____ | <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Infusion | <input type="checkbox"/> DME |
| <input type="checkbox"/> Medical Supplies | Height: ____ Ft ____ In |
| <input type="checkbox"/> Other: _____ | Weight: ____ Lbs |
| <input type="checkbox"/> Therapy*: | |

| Type | Times/Week | Number of Weeks |
|------|------------|-----------------|
| PT | | |
| OT | | |
| ST | | |

*Treatment plan and progress notes required

Codes & Descriptions:

| ICD Code | ICD 9 Description |
|----------|-------------------|
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| | |
| | |

| CPT/HCPC Code | CPT/HCPC Description |
|---------------|----------------------|
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. Comments: _____