



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: