

**PM Form 3.14.3 TRBHA PRIOR AUTHORIZATION REQUEST FORM**

INSTRUCTIONS

- A. This form is completed by the TRBHA staff prior to admission as follows:
- **For non-emergency admissions**, this form is completed prior to admission, 8:00 a.m. to 5:00 p.m. Monday through Friday.
  - **For emergency admissions**, this form is completed within 24 hours or the next business day of an admission made after 5:00 p.m. on Monday through Friday, on weekends or State holidays.
- B. The form is faxed to ADHS/BQMO at **(602) 364-4697**. ADHS/BQMO completes Section II of the form and returns the form to the TRBHA staff. This form must be accompanied with the following:
- Certification of Need for Acute Hospital/Inpatient, Sub-acute and RTC
  - Treatment plan/service plan

**Section I** (to be completed by TRBHA staff)

Client Name: \_\_\_\_\_ Date of Birth:    /    /

Client ID #: \_\_\_\_\_ TRBHA Name: \_\_\_\_\_

AHCCCS ID #: \_\_\_\_\_ TRBHA Staff: \_\_\_\_\_

Diagnosis *(Must be numeric value per ICD 9 criteria)*: \_\_\_\_\_

Proposed Placement: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider ID #: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Length of Stay: \_\_\_\_\_

Requested Service Dates:    From:    /    /                      To:    /    /

Service Code: \_\_\_\_\_

Type of Service Requested:     Acute Hospital/Inpatient                       Sub-acute                       RTC

Program Type:                       GMH                       SMI                       Child/Adolescent                       Drug/Alcohol

TRBHA Staff Signature: \_\_\_\_\_ Date:    /    /

**Section II** (to be completed by ADHS/BQMO)

Action:     Approved                       Denied

If denied, explain (cite specific criteria not met): \_\_\_\_\_

Approved Length of Stay: \_\_\_\_\_ Approved Service Dates: \_\_\_\_\_

Authorization Number: \_\_\_\_\_

Authorized ADHS/BQMO Signature: \_\_\_\_\_ Date:    /    /