



**PRIOR AUTHORIZATION FORM**

Date: \_\_\_\_\_ Clinic: \_\_\_\_\_

Requesting Provider: \_\_\_\_\_

Requesting Provider's Phone: \_\_\_\_\_

Primary Provider Name: \_\_\_\_\_

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

Proposed date of Service: \_\_\_\_\_

Proposed Service to be provided: \_\_\_\_\_

CPT Codes: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Comments/Narrative:

\_\_\_\_\_  
\_\_\_\_\_

Signature of requesting physician or designee: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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***Below to be completed by ADHS***

Approved

Disapproved

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

**Please fax to: 602-542-7520 (Virginia Warren, Cancer Control Programs Office Chief)**