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 or within 24 hours of an admission (for requests made after 5:00 p.m. Monday through Friday).
- **For emergency admissions**, this form is completed for persons age 21 or older, within 72 hours of admission; and for persons under the age of 21, within 14 days of admission.

B. The form is faxed to ADHS/BQ& I at **(602) 364-4697**. ADHS/BQ& I completes Section II of the form and returns the form to the TRBHA staff.

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

☐ Behavioral Health Inpatient Facility (formerly RTC)

☐ Behavioral Health Residential Facility ☐ HCTC

Program Type: ☐ GMH ☐ SMI ☐ Child/Adolescent ☐ Drug/Alcohol

TRBHA Staff Signature: ______________________________ Date: / /

Section II (to be completed by ADHS/BQ& I)

Action: ☐ Approved ☐ Denied

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

Approved Length of Stay: Approved Service Dates:

Authorization Number:

Authorized ADHS/BQ& I Signature: ____________________________________ Date: / /