

MEDICAL TREATMENT PREAUTHORIZATION FORM

*Instructions for using this form are available at <https://www.azica.gov/forms/mro7701>.

SECTION I – PROVIDER REQUEST FOR PREAUTHORIZATION (PROVIDER TO COMPLETE/SUBMIT TO PAYER)

PATIENT/EMPLOYEE INFORMATION

Name (Last, First, Middle):

Date of Injury (MM/DD/YYYY):

Date of Birth (MM/DD/YYYY):

Payer Claim No.

Social Security Number:¹

PROVIDER INFORMATION

Name:

Contact Name:

Phone:

Specialty:

Preferred Method of Contact: E-mail Fax

E-mail or Fax:

PAYER INFORMATION

(Self-Insured Employer, Insurance Carrier, Third-Party Administrator, or Special Fund)

Name:

Contact Name:

Diagnosis/ICD Code

Treatment/Services Requested Urgent Routine

CPT/NDC Code

I have attached documentation to support the medical necessity and appropriateness of the treatment/services requested.

Original sent to **Payer** via: U.S. Mail E-mail Fax

Requested Treatment/Services Supported by ODG? Yes No Unknown

Payer Mailing Address, Fax, or Email:

Provider Signature:

Date Sent:

SECTION II – PAYER DECISION ON REQUEST FOR PREAUTHORIZATION (Payer Decision supported by IME? Yes No)

Preferred Method of Contact: E-mail Fax

E-mail or Fax:

Date Req. for Preauthorization Received:

ICA Claim No.:

Payer Response: Approved Partially Denied Denied Request for Preauthorization Incomplete IME Requested

I have attached a statement of the approved treatment/services or, if not approved, the reasons supporting a denial/partial denial.

Original sent to **Provider** via Provider's Preferred Method of Contact (see above).

Copy to: Employee Employee's Attorney

Payer Signature:

Date Sent:

SECTION III – PROVIDER OR EMPLOYEE REQUEST FOR RECONSIDERATION OF PAYER DECISION

I have attached a statement of the reasons and justifications supporting the Request for Reconsideration.

I have attached documentation to support the medical necessity and appropriateness of the treatment/services requested.

Original sent to **Payer** via Payer's Preferred Method of Contact (see Section II above).

Provider or Employee Signature:

Date Sent:

SECTION IV – PAYER DECISION ON REQUEST FOR RECONSIDERATION (Payer Decision supported by IME? Yes No)

Payer Response: Approved Partially Denied Denied IME Requested

Date Req. for Reconsideration Received:

I have attached a statement of the approved treatment/services or, if not approved, the reasons supporting a denial/partial denial.

Original sent to **Provider** via Provider's Preferred Method of Contact (see above).

Copy to: Employee Employee's Attorney

Payer Signature:

Date Sent:

SECTION V – PROVIDER OR EMPLOYEE REQUEST FOR ADMINISTRATIVE PEER REVIEW (SUBMIT TO ICA)

Reason for Request for Administrative Review: Payer Non-Response Denial/Partial Denial of Requested Treatment/Services

I have attached copies of all relevant medical records and (if applicable) documentation related to Payer's non-response.

I have attached copies of all documentation and statements previously attached to Sections I-IV (above).

Original sent to **ICA MRO** via: U.S. Mail (800 W. Washington St., Phoenix, AZ 85007) E-mail (MRO@azica.gov) Fax (602-542-4797)

Provider or Employee Signature:

Date Sent: