Schaller Anderson of AZ, L.L.C.
2800 North Central Avenue, Suite 400
Phoenix, AZ 85004
Phone: (602) 798-2745 or (888) 836-8147
Fax: (602) 659-1965 or (800) 573-4165

PRIOR AUTHORIZATION FOR FAMILY PLANNING SERVICES

Date: ________________________

M.D./D.O.: ____________________________________ Phone: (_____) _______________

Office Address: ____

Contact: ______________________________________ Fax: (______) _________________

Member Name: ____

I.D. #: ___________________________________ DOB: _____________________________

PA Requested For: ___________________________________ CPT Code: ______________
(Procedure)

Date Procedure is scheduled: __________________ Facility: _____________________

Facility Address: ____

Facility Phone: (________) ________________ Facility Fax: (______) _______________

(Remember to send copy of signed and dated sterilization consent form)

FOR SCHALLER ANDERSON USE ONLY:

Date Received: _____________________ Authorized By: ___________________________

Date Authorized: __________________ Consent: Yes__________ No_________

PRIOR AUTHORIZATION
NUMBER: ____

Fax to Facility – Date ______________ Time____________ Initials _______________

Fax to Physician – Date _________________ Time____________ Initials _________

Authorization is subject to eligibility on date of service. If member is determined to be ineligible on date of service, the member may be responsible for these services. To ensure proper payment for services rendered, referral provider/facility must verify eligibility on date of service.