MEMBER NAME	*AHCCCS ID#*
DATE OF BIRTH	*CONTRACTOR NAME*

The Contractor shall make every reasonable effort to contact the provider to confirm the qualifying diagnosis/condition within 24 hours of receiving the Prior Authorization (PA) request for a pregnancy termination. Except for circumstances beyond the control of the Contractor, a failure to confirm the diagnosis/condition within 24 hours may result in corrective actions and/or Administrative Action by AHCCCS.

Requesting Provider is the provider confirming the qualifying diagnosis/condition via the following:

- ☐ Laboratory Results
- ☐ Diagnostic Testing Results
- ☐ Written Provider Consultation Report

When the requesting provider is NOT the provider confirming the qualifying diagnosis/condition, the Contractor shall contact and request documentation from the provider that determined the member had the qualifying diagnosis condition. The Contractor requested and received the following:

- ☐ Laboratory Results
- ☐ Diagnostic Testing Results
- ☐ Written Provider Consultation Report

PROVIDER INFORMATION

NAME OF PROVIDER CONTACTED	*TELEPHONE NUMBER*
FACILITY/PRACTICE NAME	*ADDRESS*

Effective Dates: 09/01/09, 09/01/11, 10/01/13, 09/01/16, 01/10/18, 10/01/18, 10/01/19, 09/01/21, 01/25/23, 01/30/24, 10/01/24, 01/01/27
Approval Dates: 09/01/09, 09/01/11, 10/01/13, 09/01/16, 11/16/17, 09/06/18, 10/03/19, 05/20/21, 11/22/22, 11/09/23, 07/05/24, xx/xx/xx

An authorization decision shall be made after contact is made with the provider that determined that the member had the qualifying diagnosis/condition, and the supporting documentation has been received.

_____

NAME OF CONTRACTOR REPRESENTATIVE COMPLETING VERIFICATION

_____ _____

SIGNATURE *DATE*

DRAFT

Effective Dates: 09/01/09, 09/01/11, 10/01/13, 09/01/16, 01/10/18, 10/01/18, 10/01/19, 09/01/21, 01/25/23, 01/30/24, 10/01/24, 01/01/27

Approval Dates: 09/01/09, 09/01/11, 10/01/13, 09/01/16, 11/16/17, 09/06/18, 10/03/19, 05/20/21, 11/22/22, 11/09/23, 07/05/24, xx/xx/xx