Health Choice Arizona
Medical Referral Form

FAX: 1-855-432-2494 or 480-800-6703

Please fill out the form completely and legibly.

Member Name (Last, First)	Member ID#	DOB	Date

Requesting Provider Name	TIN#	NPI#:	PCP (if different)

Office Contact Person	Direct Phone #	Fax #

Diagnosis 1 (include ICD-10)	Diagnosis 2	Diagnosis 3

Please send all pertinent clinical documentation with this fax.

Contracted Provider Name	Specialty	Phone Number	Fax Number

Contracted Facility	Address	NPI Number

Name of Procedure/Service Requested				
CPT Codes Requested				

☐ Please check if this request is for continuity of care.