

# 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.

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