

**ALTERNATIVE SETTING SPECIALITY RATE  
PRIOR AUTHORIZATION REQUEST**

SECTION A. REQUESTOR INFORMATION		
<b>Fax completed form and documentation to:</b> AHCCCS/DFSM/Tribal ALTCS Fax: (602) 254-2426 or Fax: (602) 256-6591	TRIBAL ALTCS PROGRAM	
	CASE MANAGER NAME	
	PHONE/FAX NUMBER	
SECTION B. MEMBER INFORMATION		
	MEMBER NAME:	
	DOB:	
	AHCCCS ID:	
SECTION C. PRIOR AUTHORIZATION REQUEST		
<b>Nurse Review</b> – New Rate will <u>not</u> affect the current CES.		<b>Nurse &amp; Coordinator Review</b> - New Rate <u>will</u> affect the current CES.
<b>Date:</b>		<b>Date:</b>
<u><b>Documents Attached</b></u> Clinical Documentation (including Service/Treatment Plan) within the past 30 days Behavioral Health Memory Care TBI Wandering/Dementia Blended Rate Supporting Documentation Provider Name/PID New Face Sheet with <b>new</b> date spans <u><b>Note:</b></u> Do not utilize a previous Face Sheet with previous date spans as it will be marked as a duplicate and closed		<u><b>Documents Attached</b></u> Clinical Documentation (including Service/Treatment Plan) within the past 30 days Behavioral Health Memory Care TBI Wandering/Dementia Blended Rate Supporting Diagnosis Provider Name/ID New Face Sheet with <b>new</b> date spans <u><b>Note:</b></u> Do not utilize a previous Face Sheet with previous date spans as it will be marked as duplicate and a duplicate and closed without review.  CES Overcost Checklist Cover Letter Case Notes CA161 and CA160 Screen Prints Person Centered Service Plan (PCSP) Uniform Assessment Tool (UAT)
SECTION C. ATTACH ALL REQUIRED DOCUMENTATION.		
NOTE: If all necessary documents are not included in the request the request/packet cannot be processed.		
Signatures acknowledge that both Tribal ALTCS Case Manager and Supervisor have reviewed and submitted the necessary documentation to proceed with ALF BH Rate and/or CES Overcost.	<u><b>SIGNATURES</b></u>	
	CASE MANAGER	
	SUPERVISOR	