|  |  |  |
| --- | --- | --- |
|  |  |  |
| *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* | |

**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* |