



Panel Addition Request Form

Fax to (480) 212-5860

Or email to eligibilityteam@iasishealthcare.com

****Please allow up to 72 hours for processing****

Date: _____ Request Made By: _____

Provider ID number: _____ Provider Name: _____

Name & Address of Facility: _____ Telephone Number: _____

_____ Fax Number: _____

| AHCCCS ID NUMBER | Member's Name | Member's Date of Birth | Date of Service MM/DD/YY | For HCA/HCG Use only | |
|------------------|---------------|------------------------|--------------------------|--------------------------------------|------------------------------------|
| | | | | Approved <input type="checkbox"/> | Denied <input type="checkbox"/> |
| | | | | Approved <input type="checkbox"/> | Denied <input type="checkbox"/> |
| | | | | Approved <input type="checkbox"/> | Denied <input type="checkbox"/> |
| | | | | Approved <input type="checkbox"/> | Denied <input type="checkbox"/> |
| | | | | Approved <input type="checkbox"/> | Denied <input type="checkbox"/> |
| | | | | Approved <input type="checkbox"/> | Denied <input type="checkbox"/> |

PCP or Office Manager Signature: _____ Date: _____

If you have any questions please contact your Network Services Representative at 1.800.322.8670

FOR HCA/HCG USE ONLY

Confirmation Sent to Provider: Yes No Date Sent: _____

Comments:

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