mercy care

Phone (602) 263-3000
Toll Free (800) 564-5465
Fax: 1-844-424-3976

Request For Prior Authorization Inpatient Eating Disorder

PLEASE TYPE ALL INFORMATION. Incomplete Requests will not be processed

Service Requested by: **Contact Number:**

Member Name: **DOB**:

AHCCCS #:

Guardian: ☐**Yes** ☐**No Who** ☐**Parent**:

DCS:

Treating Doctor/NP Name : **Phone/ Email**:

Clinic: **Phone/ Email:**

Case Manager: **Phone/ Email:**

Requesting clinician/ title: **Phone/Email**:

Current location of member: (*i.e. inpatient, foster care, family, home*)

Other Insurance If AHCCCS is not primary:

Current psychiatric diagnosis:
Date of last visit with treating psychiatrist:
Please *attach* last psychiatric progress note or evaluations:
Symptoms requiring inpatient hospitalization:
Mental status:
Current substance use and history:
Current psychiatric medications:
Past history of treatment for eating disorder:

Current height:	
Current weight:	**Date:**
BMI:	
Amount of weight loss over last 3 months:	

Current medical diagnosis:	
Current medical medications:	
PCP name and phone number:	**Date last seen:**
Any medical hospitalizations during last 3 months:	
Is member medically stable?	
Please attach current Labs and last medical progress note	