



PINAL COUNTY  
Wide open opportunity

PINAL/GILA LONG TERM CARE  
**REQUEST FOR REFERRAL  
INCONTINENCE SUPPLIES**  
PLEASE FAX ALL REQUESTS TO (520)866-6717

Member Name: \_\_\_\_\_ ID# \_\_\_\_\_ DOB \_\_\_\_\_  
 Medicare A  B  Other Insurance \_\_\_\_\_  
 Name of Nursing Home/ALF \_\_\_\_\_  
 EPSDT eligible member? Yes  No  CRS eligible member? Yes  No   
 Service Provider Number: \_\_\_\_\_  
 (AHCCCS# of provider referred to)  
 Service Provider Name: \_\_\_\_\_  
 (Name of Provider referred to)  
**Service Requested:** \_\_\_\_\_  
**URGENCY STATUS for Radiology Services (see \* for definitions of status):**  
 Standard (Based on members condition – Not to exceed 14 days)  
 Expedited – Urgent (within 3 days)

**For Incontinence Supplies the following questions must be completed:**

1. What is the age of the member?
2. Are the supplies to be used to manage incontinency?
3. What is the diagnosis causing the member's incontinence?
4. What is the frequency of the incontinence?  
 Total   
 Frequent   
 Occasional   
 Nocturnal   
 Yes  No
5. Are the supplies to be used to manage wound care?  
 If yes, describe the wound: \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_ Appointment Time: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_  
 Requested CPT Code: \_\_\_\_\_ Est. Cost: \_\_\_\_\_

**PCP/PCP Designee Signature** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
 \_\_\_\_\_ **Fax:** \_\_\_\_\_  
 PCP Remember: It is your responsibility to assure a copy of this consult/treatment is present in your office/facility medical records

**For requests please attach documentation to support medical necessity (Mandatory)**

1. PCP script (if referral form not signed by PCP)
2. Most recent History and Physical
3. Physical progress notes, which evaluate condition requiring incontinence supplies.

**\*Standard Authorization Request:** A request for which P/GLTC provides a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request with a possible extension of up to 14 calendar days if the member or provider requests an extension of the P/GLTC establishes a need for additional information and delay is in the enrollee's best interest.

**\*Expedited authorization Request:** A request for which P/GLTC provides a decision to the member as expeditiously as the enrollee's health condition requires, but not later than three working days following the receipt of the authorization request with a possible extension of up to 14 days if the member or provider requests an extension or if P/GLTC establishes a need for additional information and delay is in the enrollee's best interest.