



PINAL/GILA LONG TERM CARE  
REQUEST FOR REFERRAL  
**INITIAL DIALYSIS NOTIFICATION**  
PLEASE FAX ALL REQUESTS TO **520-866-6717**

**DIALYSIS CENTER**

**DIALYSIS CENTER AHCCCS ID#:** \_\_\_\_\_

**NAME OF NEPHROLOGIST:** \_\_\_\_\_

**NEPHROLOGIST AHCCCS ID#:** \_\_\_\_\_

**MEMBER NAME:** \_\_\_\_\_

**MEMBER AHCCCS ID#:** \_\_\_\_\_

**MEMBER DATE OF BIRTH:** \_\_\_\_\_

**URGENCY STATUS:**       Standard (Based on members condition – Not to exceed 14 days)  
 Expedited – Urgent (within 3 days)

**TYPE OF DIALYSIS SERVICE:** \_\_\_\_\_

**ADDITIONAL PROCEDURES TO BE PERFORMED OR PROVIDED (CPT OR HCPCS)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DAYS OF THE WEEK DIALYSIS WILL BE DONE (circle) M TU W TH F S**

**DATE DIALYSIS TO START** \_\_\_\_\_

**TIME OF DIALYSIS SESSIONS** \_\_\_\_\_

**COMMENTS** \_\_\_\_\_

\_\_\_\_\_

**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**

**\*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.