



SCHALLER ANDERSON  
OF ARIZONA, L.L.C.

**Schaller Anderson of AZ, L.L.C.**  
4350 E. Cotton Center Blvd., Bldg. D  
Phoenix, AZ 85040  
Phone: (602) 798-2745 or (888) 836-8147  
Fax: (602) 659-1965 or (800) 573-4165

**PRIOR AUTHORIZATION FOR FAMILY PLANNING SERVICES**

Date: \_\_\_\_\_

M.D./D.O.: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Office Address: \_\_\_\_\_

Contact: \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

Member Name: \_\_\_\_\_

I.D. #: \_\_\_\_\_ DOB: \_\_\_\_\_

PA Requested For: \_\_\_\_\_ CPT Code: \_\_\_\_\_  
(Procedure)

Date Procedure is scheduled: \_\_\_\_\_ Facility: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Facility Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Facility Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

**(Remember to send copy of signed and dated sterilization consent form)**

**FOR SCHALLER ANDERSON USE ONLY:**

Date Received: \_\_\_\_\_ Authorized By: \_\_\_\_\_

Date Authorized: \_\_\_\_\_ Consent: Yes \_\_\_\_\_ No \_\_\_\_\_

PRIOR AUTHORIZATION  
NUMBER: \_\_\_\_\_

Fax to Facility - Date \_\_\_\_\_ Time \_\_\_\_\_ Initials \_\_\_\_\_

Fax to Physician - Date \_\_\_\_\_ Time \_\_\_\_\_ Initials \_\_\_\_\_

Authorization is subject to eligibility on date of service. If member is determined to be ineligible on date of service, the member may be responsible for these services. To ensure proper payment for services rendered, referral provider/facility must verify eligibility on date of service.