PM FORM 3.14.4

Northern Arizona Regional Behavioral Health Authority

DOPA FORM

(Denial of Prior Authorized Service)

Clearly type or print all information; all blanks must be completed or form will be returned.

MEMBER'S NAME:		**MEMBER'S ID NUMBER**	
MEMBER'S SAA/TAA:		**CLINICAL LIAISON NAME AND PHONE:**	

TYPE OF PRIOR AUTHORIZED SERVICE REQUESTED (check one):

- ☐ **Non-emergency Level I Inpatient Admission or Continued Stay**
- ☐ **Level I Residential Treatment Center Admission or Continued Stay**

NOTE: This form is only used for denials of the above services.

OTHER INFORMATION ABOUT THE REQUESTED SERVICE:

Date and time the Request was Received by the SAA/TAA:		**Name of the Person who Requested the Service:**	
Date and Time of the SAA/TAA Physician Denial Decision:		**Typed Name and Phone # of the SAA/TAA Physician Making the Denial:**	

REASON FOR THE DENIAL OF THIS REQUESTED SERVICE (check one):

- ☐ **The requested service is not a covered benefit for this member**
- ☐ **Member does not require this intensity of service and lower intensity is available**
- ☐ **Other:** ____

Signature of the Physician Denying the Service:		**Date of Physician's Signature:**	

Attach the Following Documentation to the Form **(DOPAs without required documents will be returned):**

- ☐ **Copy of the "Notice of Action" Grievance/Appeal Notification Form Given to the Member/Guardian**
- ☐ **Copy of the Physician's Note Providing Clinical Justification for the Denial Decision from the Member's Chart (Note must be written and signed by the physician who signed above. Note must be dated on or before the date of the signature above.)**

1. **Fax this form with required documents within 24 hours to NARBHA QM DIRECTOR at 928-774-5665.**
2. **Fax form to provider of services within 24 hours of denial.**
3. **File a copy of this DOPA form in the member's clinical record.**

Date and Initials of the Person Faxing to NARBHA:____________ to Service Provider: ____________