

**NARBHA
TEMPORARY PRESCRIBER OVERRIDE FORM**

TO: Northern Arizona Regional Behavioral Health Authority
FAX: (928) 913-0399 ATTN: MIS Specialist Unit

FROM: Name: _____ Date: _____

MEMBER INFORMATION

Name: _____

ID: _____ DOB: _____

This authorization will add the following prescriber for this member only. Temporary prescribers are not added to the NARBHA Prescriber Panel.

Please **ADD** the following temporary prescriber for the member listed above.

Prescriber Name:	
DEA Number:	
NPI Number:	
Effective Start Date:	____/____/____

Please note: NARBHA can only authorize a temporary prescriber for a period of 5 days. If additional days are required a new authorization will need to be submitted.

NARBHA PROVIDER AUTHORIZATION:

Authorized by (print name): _____

Title: _____

Signature: _____ Date: _____