PM Form 3.16.8
PRESCRIBER REGISTRATION FORM

TO: **Northern Arizona Regional Behavioral Health Authority**
FAX: (928) 913-0399 **ATTN: MIS Specialist Unit**
FROM: Name:_______________________________ Clinic/Site: ____________________

☐ Please **ADD** the following prescriber to the NARBHA Authorized Prescriber Panel

NARBHA-Contracted Behavioral Health Facilities or Medical Practitioners may submit the form but are strongly encouraged to first contact NARBHA MIS Specialists to determine if a prescriber is already on the prescriber panel and to be referred to the NARBHA Medical Director to answer questions about the formulary. New prescribers will be mailed a New Prescriber Orientation Packet and are required to submit an attestation that the packet has been reviewed.

Prescriber Name:	
DEA Number:	
NPI Number:	
Effective Start Date:	_____/_____/_____
Prescriber address if different from Clinic/Site:	

☐ Please **DELETE** the following prescriber from the NARBHA Authorized Prescriber Panel

Be sure to consider outstanding valid prescriptions by the prescriber when deciding on the stop date.

Prescriber Name:	
DEA Number:	
Effective Stop Date:	_____/_____/_____

AUTHORIZATION

NARBHA-Contracted Behavioral Health Facility or Provider:

____ Phone:(____)________

Address: ____

City:____________________________State:_________ Zip: _______________

Authorized by (print name):____
Title:____

Signature:____ Date: ___________________

NARBHA USE ONLY:

Date sent to SXC: _________________ **By:** ________________________ **OR**
Date entered by NARBHA:__________ **By:** ________________________
Copy to: **Medical Systems Analyst (MSA)**
Date New Prescriber Orientation Packet sent by MSA: ___________________
Date New Prescriber returned attestation: ______________________________