Banner
University Family Care

OOH Between Facility Transfer Request

This form is to be used to request transfers of members in out of home treatment to another same type location.

Email Completed Form to the BUHPBHUMPAMailbox@bannerhealth.com

This request is to be typed

Date: ________________

Reason for request: ☐ Clinical ☐ Administrative

Member Name: ______________________________________
AHCCCS ID # ________________________

Date of Admit to Current Facility: _______________________
Name of Current Facility: ______________________________

Contact Name: ______________________________ Phone Number: _________________________________
Email Address of Person making this request: ____

Date of Requested Transfer: ____
Name of Facility Member will Transfer to: ______________________________
Address of Transfer Location: _______________________________________

Contact Name: ______________________________
Number at transfer location who can verify member's acceptance? ________________________________

Reason member needs to be transferred: ____
____
____
____
____
____
____

Goals member will work on at new facility?

1. ____
2. ____
3. ____

A determination will be made within 2 business days of receipt.