Banner University Health Plans
Banner – University Family Care

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.