BlueCross. BlueShield.
Federal Employee Program

Prior Authorization Request Form ***Incontinence Treatment System***

Notice: The Federal Employee Program has a 15 Day turn-around time on all Prior Authorization Requests According to the Blue Cross Blue Shield Service Benefit Plan
Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Patient Information	
Patient's Name:	Blue Cross Blue Shield ID Number: R
Birth Date:	Patient's Phone Number:
Billing Provider Information	**Ordering Physician/Provider Information**
Name and Address:	☐ Please check this box if the ordering and billing provider are the same Provider's Name and Address:
Tax ID Number:	Tax ID Number:
Office Contact:	Office Contact:
Phone: ( )	Phone: ( )
Fax: ( )	Fax: ( )

Please enter all codes requested; "by report" codes must have a description of why the code is being used.

ICD-10 CODE(S):

CPT CODE(S):

HCPCS CODE(S):

PATIENT CLINICAL INFORMATION

Please provide the following documentation: Anticipated Date(s) of Service:

- History and physical including type and severity of urinary incontinence, prior treatment and response, reason for procedure
- Type of substance injected

View our Medical Policy on line at http://www.fepblue.org/medical-policies.jsp