blue of california

Prior Authorization Request Form

(Please choose the appropriate policy for this request)

☐ Microwave and Locoregional Laser Tumor Ablation

☐ Radiofrequency Ablation of Primary or Metastatic Liver Tumors

Standard Fax Number: 1 (844) 807-8997	**Urgent Fax Number:** 1 (844) 807-8996

Use AuthAccel - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

Notice: Blue Shield of CA has a 5 Business Day turn-around time on all Standard Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

☐ New Standard Request ☐ New Urgent Request ☐ Standing Referral

Important For Urgent Requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. ***If there is no MD signature present the request will be processed as a Standard request.***

MD Signature REQUIRED For Urgent Requests Only:

☐ **Modification Or** ☐ **Extension Requests Complete the Section Below:**

Date Last Authorized:	Previous Authorization Number:
MD/NP/PA justification for modification or extension:	

Patient Information:

First Name:	Last Name:
Date of Birth:	ID Number:
Address:	

Referring/Prescribing Provider:

Name:			NPI:	
Street Address + Suite #:				
City:	State:	Zip:	Phone:	Fax:
Type of Provider: ☐ PCP ☐ Specialist Type:			Contact Name and Phone Number:	

Servicing/Billing: Provider/Vendor/Lab ***If same as Referring/Prescribing Provider Check Here*** ☐

Name:	Tax ID:	NPI:
Street Address + Suite #:		

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City:	State:	Zip:	Phone:	Fax:
Specialist Type:			Contact Name and Phone Number:	

If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:

Group Name:		NPI:
Street Address + Suite #:		
City:	State:	Zip:

Billing Facility (If Applicable):

Facility Name:			NPI:	
Street Address + Suite #:				
City:	State:	Zip:	Phone:	Fax:
Contact Name and Phone Number:				

Anticipated Date of Service:	**If Lab, Draw Date:**

Place of Service: (Check One Box Only or If typing replace box with an "X"):

☐ Office	☐ Home	☐ On Campus OP Hosp
☐ Acute Rehab	☐ Hospice	☐ PHP
☐ Ambulance- Air or Water	☐ Independent Clinic	☐ RTC – Psychiatric
☐ Ambulance-Land	☐ Independent Laboratory	☐ RTC – SUD
☐ Ambulatory Surgical Center	☐ Inpatient Hospital	☐ Skilled Nursing Facility
☐ Assisted Living Facility	☐ Intermediate Care Facility	☐ Telehealth
☐ Birthing Center	☐ IOP	☐ Urgent Care Facility
☐ Custodial Care Facility	☐ IP Psychiatric Facility	☐ Other - Please Specify:
☐ End Stage Renal Disease Tx	☐ Nursing Facility	
☐ Group Home	☐ Off Campus OP Hosp	

Please enter all codes requested; unlisted codes must have a description.
Please include the quantity for each code requested and if applicable, left, right or bilateral designations.

ICD-10 Code(s):

CPT/HCPC Code(s):

For questions: Call BSC Medical Care Solutions Phone Number: 1-800-541-6652

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Please provide the following documentation:

☐ **Microwave and Locoregional Laser Tumor Ablation**

☐ **History and physical and/or consultation notes including:**
- ☐ Clinical indications/justification of procedure
- ☐ Eastern Cooperative Oncology Group functional status (if applicable)
- ☐ Previous treatment(s), duration and response(s)
- ☐ Treatment Plan
- ☐ Tumor type and description (i.e., resectable or unresectable, primary or metastatic, tumor burden [e.g., liver dominant])
- ☐ Pertinent radiological imaging results (i.e., abdominal CT and/or MRI and/or PET)
- ☐ Pathology report including tumor node metastasis (TNM) classification
- ☐ Current serum chemistry, liver function tests, and tumor marker results

Visit our website at blueshieldca.com

Please provide the following documentation:

☐ **Radiofrequency Ablation of Primary or Metastatic Liver Tumors**

☐ **History and physical and/or consultation notes including:**
- ☐ Clinical indications/justification of procedure including reason why the lesion(s) are inoperable
- ☐ Eastern Cooperative Oncology Group functional status (if applicable)
- ☐ Previous treatment(s), duration and response(s)
- ☐ Treatment Plan
- ☐ Tumor type and description (i.e., resectable or unresectable, primary or metastatic, tumor burden [e.g., liver dominant])
- ☐ Number of location of tumors to be treated
- ☐ Transplant status and plan if appropriate
- ☐ Pertinent radiological imaging results (i.e., abdominal CT and/or MRI and/or PET)
- ☐ Pathology report including tumor node metastasis (TNM) classification
- ☐ Current serum chemistry, liver function tests, and tumor marker results

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