BlueCross BlueShield
Federal Employee Program

Prior Authorization Request Form	*7.01.108 Artificial Intervertebral Disc Cervical Spine*
Standard Fax Number: 1 (855) 895-3504	**Urgent Fax Number:** 1 (844) 244-0226

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

Notice: The Federal Employee Program has a 15 Calendar Day turn-around time on all Standard 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.

☐ **New Standard Request** ☐ **New Urgent Request**

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 #:			Email address:	
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:			NPI:	
Street Address + Suite #:			Email address:	
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 FEP Authorization Requests Phone Number: 1 (800) 633-4581

Please provide the following documentation

History and physical and/or consultation notes including:

Clinical findings

- Primary diagnosis and relevant comorbidities
- Documentation of symptom duration and severity including activity/functional limitations
- If urgent treatment is required (i.e. hospitalization or immediate surgery), documentation of:
    - Severe or rapidly progressing symptoms suggesting nerve root or spinal cord compression
- Documentation of skeletal maturity
- Relevant imaging report(s) with interpretation (i.e. MRI, CT, or myelography)

Consultation

- Specialist consultation and/or recommendation (i.e., orthopedic surgeon, pain management physician, etc.)
- Other pertinent multidisciplinary notes or reports (i.e., physical therapy, nursing, pain management, etc.)

Prior treatment

- Pertinent past procedural and surgical history including any prior cervical disc arthroplasty procedures
- Documentation of **at least 6 weeks** of conservative non-surgical treatment including:
    - Participation in physician directed pain management program with pharmacotherapy
    - Physical therapy

Rationale

- Documentation that proposed device is approved by the U.S. Food and Drug Administration (FDA)
- Please indicate proposed number of disc levels to be treated. **If multiple levels are to be treated:**
    - Documentation must include clinical findings for each level.
    - Proposed device must be FDA-approved for two levels
- Treatment plan

View our Medical Policy online at https://www.fepblue.org/legal/policies-guidelines