



Prior Authorization Request Form		<i>2.01.21 Temporomandibular Joint Disorder</i>	
Standard Fax Number: 1 (855) 895-3504		Urgent Fax Number: 1 (844) 224-0226	
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.			
<input type="checkbox"/> New Standard Request		<input type="checkbox"/> 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. <i>If there is no MD signature present the request will be processed as a Standard request.</i>			
MD Signature REQUIRED For Urgent Requests Only:			
<input type="checkbox"/> Modification Or <input type="checkbox"/> 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: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist Type:		Contact Name and Phone Number:	
Servicing/Billing: Provider/Vendor/Lab <i>If same as Referring/Prescribing Provider Check Here</i> <input type="checkbox"/>			
Name:		NPI:	
Street Address + Suite #:		Email address:	
City:	State:	Zip:	Phone: Fax:

Specialist Type:	Contact Name and Phone Number:
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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"):

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

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Please provide the following documentation

History and physical and/or consultation notes including:

Clinical findings

- Primary diagnosis and relevant comorbidities
- Pertinent symptoms and duration
- Activity and functional limitations
- Supporting laboratory results
- Relevant radiology and/or pathology report(s) with interpretation (i.e. MRI, CT, tumor pathology, etc.)

Prior treatment

- Pertinent past procedural and surgical history
- Conservative treatments including duration and response

Consultation

- Specialist consultation and/or recommendation (i.e., oral surgeon, dentist, etc.)
- Other pertinent multidisciplinary notes or reports (i.e. physical therapy, primary care provider, pain management, etc.)

Rationale

- Reason for procedure/device/imaging
- If applicable, type of imaging requested
- For planned *non-surgical* treatments:
 - Type of device or appliance. **Please note:** Devices must be approved by the U.S. Food & Drug Administration (FDA)
- For planned *surgical* treatments
 - Type of surgery planned
 - Documentation of result of conservative treatments
- How requested service is expected to affect treatment
- Treatment plan

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