blue of california

Prior Authorization Request Form	Home Health Care
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 #:		

An Independent Member of the Blue Shield Association

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	☐ PH
☐ 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	☐ Patients's Home
☐ End Stage Renal Disease Tx	☐ Nursing Facility	☐ Home Care Agency
☐ 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):
☐ S9123 (Nursing Care in the Home by RN – per hour)
☐ S9124 (Nursing Care in the Home by LPN/LVN – per hour)

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

Please provide the following documentation:

- ☐ History and physical
- ☐ Limitations that have rendered the member to be homebound
- ☐ Notes indicating the current home health treatment plan to include what skilled services will be required
- ☐ Frequency of requested visits: visit(s) per (day/week/month)
- ☐ Length of each requested visit: hour(s) for each visit
- ☐ Anticipated dates of service: / / - / / **OR** duration of request (days/months)
  - ☐ Total number of visits requested:
  - ☐ Total number of hours requested:
- ☐ Is home health requested for medication administration? Y☐/ N☐
  - ☐ If **yes**, name of the medication?
- ☐ Does the medication require prior authorization? Y☐/ N☐
  - ☐ If **yes**, please provide prior authorization number:
  - ☐ If **no**, Stop. (Submit Home Health request only after medication authorization number obtained.)
- ☐ How many home health visits has this member had already in this calendar year?

***** Please call the Customer Service number on the back of the member's ID card for benefit, maximum, and eligibility verification.**

Visit our website at blueshieldca.com