CalPERS PPO Hospital Outpatient Facility Form

Fax form to (844) 807-8997 or mail form to address at the bottom of page 2. For assistance completing the form, call (800) 541-6652. This form is submitted by providers to request approval for elective procedures from a Hospital Outpatient facility due to 1. patient safety or 2. distance to an in-network, Free-Standing Ambulatory Surgery Center (ASC).

Important instructions

- Submit form at least **five days** prior to services being rendered.
- Applicable to CalPERS PPO members.
- Form to be completed by physician.
- Patient safety and distance described below.
- Print or type your responses in the spaces below.
- Fill in all items completely. All fields are required.
- Sign your name in the space provided.
- **Errors on this form may result in your claim being delayed or denied.**

Section 1 (please mark the surgery being requested)

- ☐ Arthroscopy
- ☐ Cataract Surgery
- ☐ Diagnostic Colonoscopy
- ☐ Esophagoscopy
- ☐ Hernia Inguinal Repair (Age 5+, Non-Laparoscopic)
- ☐ Hysterectomy Uterine Tissue Sample (with Biopsy, with or without D&C)
- ☐ Laparoscopic Gallbladder Removal
- ☐ Lithotripsy - Fragmenting of Kidney Stones
- ☐ Nasal/Sinus - Corrective Surgery - Septoplasty
- ☐ Nasal/Sinus - Submucous Resection Inferior Turbinate
- ☐ Repair of Laparoscopic Inguinal Hernia
- ☐ Sigmoidoscopy
- ☐ Tonsillectomy and/or Adenoidectomy, under age 12
- ☐ Upper GI Endoscopy
- ☐ Upper GI Endoscopy with Biopsy

Referring provider information

Referring/prescribing physician's name	☐ PCP ☐ Specialist	Tax ID number NPI

Servicing provider information

Servicing provider/facility name		
Servicing facility street, city, ZIP code		Tax ID number NPI
Servicing office contact name	Phone	Fax

Member information

First name	Last name	
Member ID number	Date of birth	Gender ☐ Male ☐ Non-binary ☐ Female ☐ Other
Street address		
City	State	ZIP code

Member criteria (please select one and provide requested information)

Please select criteria which Member meets to have service(s) performed at a Hospital Outpatient Facility.

Criteria 1: Patient safety - Supporting clinical documentation, below, must be submitted with request.
☐ Comorbid condition(s) (specific comorbid condition(s) must be listed).
☐ Other extenuating circumstances (Please explain).

Required documentation includes
History and physical and/or consultation notes.
- Clinical findings (i.e., pertinent symptoms and duration)
- Comorbidities
- Consultation and medical clearance report(s), when applicable

Criteria 2: Distance to in-network ASC (please provide name and address of nearest ASC that can perform the surgery).
☐ Distance to an in-network, Free-Standing ASC is greater than 30 miles from member's address on file.

Name of ASC

Address of ASC

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)

For questions: Call Blue Shield Medical Care Solutions (800) 541-6652

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Physician signature

By signing, I certify the information on this form to be factual for this member; due to concerns for the patient's safety it is unsafe to have the selected procedure performed in a free standing ambulatory surgical center; or, that the closest in-network ASC is greater than 30 miles from the member's home address.

Physician signature | Date

Physician's typed or printed name

Fax: **(844) 807-8997**

Mail: **P.O. Box 629005**
El Dorado Hills, CA 95762-9005