BlueCross BlueShield
Federal Employee Program

Prior Authorization Lab Request Form	*2.04.33 Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer*
Standard Fax Number: 1 (855) **479-9484**	**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
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Consultation

- Specialist consultation and/or recommendation (i.e., oncologist, surgeon, etc.)

Prior evaluation

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Rationale

- Name of requested test
- How requested testing is expected to affect treatment
- Treatment plan

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