



**BlueCross  
BlueShield**

Federal Employee Program.

<b>Prior Authorization Request Form</b>		<b>Service Requested</b>	
Fax Number: 1 (855) 895-3504		Phone Number: 1 (800) 633-4581	
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 ( <a href="http://www.blueshieldca.com/provider">www.blueshieldca.com/provider</a> ) and click the Authorizations tab to get started.			
Notice: The Federal Employee Program has a 15 Day turn-around time on all 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 Request For <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:			
<b>Patient Information:</b>			
First Name:		Last Name:	
Date of Birth:		ID Number:	
<b>Referring/Prescribing Provider:</b>			
Name:		Tax ID:	NPI:
Street Address + Suite #:			
City:	State:	Zip:	Phone: Fax:
Type of Provider: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist Type:			
<b>Servicing/Billing: Provider/Vendor/Lab</b> <i>If Referring or Prescribing Provider are the Same Check Here <input type="checkbox"/></i>			
Name:		Tax ID:	NPI:
Street Address + Suite #:			
City:	State:	Zip:	Phone: Fax:
Specialist Type:		Contact Name:	

**If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:**

Group Name:		Tax ID:	NPI:
Street Address + Suite #:			
City:	State:	Zip:	

**Billing Facility (If Applicable):**

Facility Name:		Tax ID:	NPI:
Street Address + Suite #:			
City:	State:	Zip:	Phone:
			Fax:

Contact Name:

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

**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):

This facsimile transmission may contain protected and privileged, highly confidential medical, Personal and Health Information (PHI) and/or legal information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate, or otherwise distribute it. If you are not the intended recipient, or if you have received this transmission in error, please notify the sender immediately and **confidentially** destroy the information that faxed in error. Thank you for your help in maintaining appropriate confidentiality.

**Please provide the following documentation:**

**History and physical and/or consultation notes including:**

- Tests required
- Purpose of testing
- Outstanding issues related to differential diagnosis or rule-out diagnoses to be evaluated
- Application of results, DSM-IV Diagnosis(es)
- Total hours requested for testing

Other pertinent multidisciplinary notes/reports: (e.g., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management) when applicable.

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