



Federal Employee Program

Prior Authorization Request Form Orthognathic Surgery

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.

Patient Information

Patient's Name:	Blue Cross Blue Shield ID Number: R
Birth Date:	Patient's Phone Number:

Billing Provider Information

Ordering Physician/Provider Information

Name and Address:	<input type="checkbox"/> Please check this box if the ordering and billing provider are the same Provider's Name and Address:
Tax ID Number:	Tax ID Number:
Office Contact:	Office Contact:
Phone: ()	Phone: ()
Fax: ()	Fax: ()

Please enter all codes requested; "by report" codes must have a description of why the code is being used.

ICD-10 CODE(S):

CPT / HCPC CODE(S):

PATIENT CLINICAL INFORMATION

Please provide the following documentation: Anticipated Date(s) of Service:

- History and physical or consultation notes including:
 - Description of the specific anatomic deformity present
 - Diagnosis and evaluation
 - Previous management of the functional medical impairment (if applicable)
 - Symptoms related to the orthognathic deformity (if applicable)
- Medical diagnostic quality (clear) intra-oral and extra-oral photographs, two-view head photograph (front and side view)
- Bilateral cephalometric radiographs with measurements
- Cephalometric tracings and/or analysis
- Additional reports:
 - Current study models with the appropriate bite registration or representation of patients pre-surgical centric occlusion and /or centric relation bite ******Please do not submit moldings******
 - Panorex x-ray or tomograms
 - Documentation demonstrating completion of skeletal growth for cases under the age of 18 (except for Class II malocclusion-mandibular retrognathic)

View our Medical Policy on line at <http://www.fepblue.org/medical-policies.jsp>

Fax Number: 1-855-895-3504

Phone Number: 1-800-633-4581

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.

Revised: Effective: