blue of california

Prior Authorization Request Form	Elective Invasive Coronary Angiography (ICA)
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 #:		

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

Please provide the following documentation:

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

- ☐ Angina class (Canadian Cardiovascular Society Grading of Angina Pectoris, Class I, II, III or IV) Unusual location of obstruction(s), unusual coronary anatomy, or unusual flow dynamics noted by the cardiologist if applicable
- ☐ Intercurrent cardiac disease (e.g., congenital heart disease, congestive heart failure, hypertrophic cardiomyopathy, kawasaki disease, post-cardiac transplant, myocardial disease, arrhythmia, valvular disease) if applicable
- ☐ Current or recent smoking history (within one year)
- ☐ Cardiologist documentation of difficult-to-control uncontrolled hypertension on maximal therapy or uncontrolled dyslipidemia on maximal therapy if applicable
- ☐ Diabetes mellitus with a first or second degree relative with premature coronary artery disease (i.e., age less than 65, MI or coronary intervention) if applicable
- ☐ Strong family history of coronary artery disease if applicable
- ☐ Prior PCI or CABG procedure if applicable
- ☐ Pertinent past procedural and surgical history
- ☐ Radiology report(s) (i.e., MRI, FFRct, CCTA)

Visit our website at blueshieldca.com