blue of california

Prior Authorization Request Form

(Please choose the appropriate policy for this request)

- ☐ Gender Affirmation Surgery
- ☐ Orthognathic Surgery
- ☐ Reconstructive Services

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 #:		

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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:

☐ Gender Affirmation Surgery

For Mastectomy, Subcutaneous Mastectomy, Breast Reduction Surgeries*:

- ☐ Age 18 or older
- ☐ DSM-5 diagnosis of gender dysphoria
- ☐ Any other medical/mental health conditions present are well-controlled
- ☐ One letter of support from a mental health professional who monitored the patient throughout psychotherapy
- ☐ Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

For Hysterectomy and Salpingo-Oophrectomy Surgeries*:

- ☐ Age 18 or older
- ☐ DSM-5 diagnosis of gender dysphoria
- ☐ Any other medical/mental health conditions present are well-controlled
- ☐ Twelve months of continuous hormone therapy or reason patient is unable to take hormones
- ☐ Two letters of support from different mental health professionals (one from the patient's psychotherapist and one that is only evaluating for surgery)
- ☐ Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

For Genital Reconstructive Surgeries*:

- ☐ Age 18 or older
- ☐ DSM-5 diagnosis of gender dysphoria
- ☐ Any other medical/mental health conditions present are well-controlled
- ☐ Twelve months of continuous hormone therapy or reason patient is unable to take hormones
- ☐ Two letters of support from different mental health professionals (one from the patient's psychotherapist and one that is only evaluating for surgery)
- ☐ Lived and worked in the desired gender role continuously for 12 months
- ☐ Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

Other Related Procedures

- ☐ Documentation (e.g., quality color photographs) clearly showing the extent of the characteristics proposed for further treatment that are outside the range of normal for the preferred gender (except for electrolysis of the pubic area, including the arm or similar region if needed prior to being used as a graft site).
- ☐ Documentation from an endocrinologist or medical provider with experience in providing hormonal therapy stating that maximal appropriate hormonal therapy has been used for at least 2 years (may include the time prior to other procedures as appropriate). Documentation should include regular clinical evaluations for response (including laboratory monitoring at least twice a year) to sex steroid hormones.
- ☐ Current (updated after any prior surgery or other treatments for gender dysphoria) documentation from a qualified mental health professional that DSM-5 criteria for gender dysphoria is present and directly related to the treatment requested.
- ☐ For voice retraining therapy or voice modification surgery, a recommendation from a speech therapist outlining the need (including whether the patient's vocal characteristics are currently outside the range of normal for the preferred gender) and treatment plan. If voice modification surgery is requested, documentation that a trial of speech therapy was tried and failed first and that surgery is likely to provide further benefit must also be submitted.
- ☐ Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

*Please refer to the Medical Policy Statement/Medical Policy Guidelines for specific details regarding requested documentation.

Visit our website at blueshieldca.com

Please provide the following documentation:

☐ Orthognathic Surgery

- ☐ History and physical and/or consultation notes including:
- ☐ Description and cause 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)
- ☐ 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 patient's pre-surgical centric occlusion and /or centric relation bite
- ☐ 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)
- ☐ Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

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Please provide the following documentation:

☐ **Reconstructive Services**

- ☐ History and physical and/or consultation notes including:
  - ☐ Clinical indications for procedure/surgery
  - ☐ Documentation of any functional problems or limitations to be corrected by the procedure including the cause of the issue
  - ☐ Previous treatment(s) and response(s) (if applicable)
  - ☐ Proposed procedural treatment plan
- ☐ Office note(s) pertaining to the clinical problem and medical necessity of the procedure requested
- ☐ Quality color photographs which accurately depicts the extent of the clinical problem (as applicable)
  Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

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