BlueCross BlueShield
Federal Employee Program

Urgent Request For Prior Authorization

Please note, scheduling issues do not meet the definition of Urgent.

Definition of an Urgent Request:

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 member.

Referring/Prescribing Physician's Name/Address + Suite#: **Tax ID Number:** **NPI:** **Is the requesting provider a:** ☐ **PCP;** ☐ **Specialist: PLEASE IDENTIFY SPECIALTY** **Phone: ( )** **Fax: ( )**	**Patient's Name:** **Birth Date:** **Member ID Number: R**
Servicing Provider/Vendor/Lab's Name and Address + Suite#: **Tax ID Number:** **NPI:** **Contact:** **Phone: ( )** **Fax: ( )**	**If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:** **Tax ID Number:** **NPI:**
Billing Facility Name and Address (If Applicable): **Tax ID Number:** **NPI:** **Contact:** **Phone: ( )** **Fax: ( )**	**Place of Service:** ☐**Physician's Office** ☐**Freestanding Ambulatory Surgery Center** ☐**Patient's Home** ☐**Home Care Agency** ☐**Outpatient Hospital Care** ☐**Long Term Care** ☐**Inpatient Hospital Care** ☐**Other (explain):** _____ **Anticipated Date of Service:** **Draw Date:**

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 CODE(S):

HCPCS CODE(S):

Please provide the following documentation:

Please provide the necessary clinical information along with the procedure fax form.

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. Please be advised the request will take up to and including 72 hours

☐ Please explain the reason for the expedited request to support the definition indicated above.

MD Signature: _____ **Please fax to BSC : 844-224-0226**

For Blue Shield of California Use Only:

☐ Request **does** meet the Urgent criteria. Please allow 72 hours from the original receipt date for a response.

☐ Request does **not** meet the Urgent criteria. Please allow 15 days from the original receipt date of the request for a response.

View our Medical Policy on line at https://www.fepblue.org/en/benefit-plans/benefit-plans-brochures-and-forms#

Non-Urgent Fax Number: 1-855-895-3504	**Phone Number: 1-800-633-4581**

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