BlueCross BlueShield
Federal Employee Program

Prior Authorization Request Form	***Service Requested***
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 (www.blueshieldca.com/provider) 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.

☐ New Request For ☐ **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:

Referring/Prescribing Provider:

Name:			Tax ID:	NPI:
Street Address + Suite #:				
City:	State:	Zip:	Phone:	Fax:
Type of Provider: ☐PCP ☐Specialist Type:				

Servicing/Billing: Provider/Vendor/Lab ***If Referring or Prescribing Provider are the Same Check Here*** ☐

Name:			Tax ID:	NPI:
Street Address + Suite #:				
City:	State:	Zip:	Phone:	Fax:
Specialist Type:			Contact Name:	

202110

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"):		
☐ Office	☐ Group Home	☐ Nursing Facility
☐ Acute Rehab	☐ Home	☐ Off Campus OP Hosp
☐ Ambulance- Air or Water	☐ Hospice	☐ PHP
☐ Ambulance-Land	☐ Independent Clinic	☐ RTC – Psychiatric
☐ Ambulatory Surgical Center	☐ Independent Laboratory	☐ RTC – SUD
☐ Assisted Living Facility	☐ Inpatient Hospital	☐ Skilled Nursing Facility
☐ Birthing Center	☐ Intermediate Care Facility	☐ Telehealth
☐ Custodial Care Facility	☐ IOP	☐ Urgent Care Facility
☐ End Stage Renal Disease Tx	☐ IP Psychiatric Facility	☐ 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):

Please provide the following documentation:	
History and physical and/or consultation notes including: • Clinical findings (i.e., pertinent symptoms and duration) • Comorbidities • Activity and functional limitations • Family history if applicable • Reason for procedure/test/device, when applicable • Pertinent past procedural and surgical history Past and present diagnostic testing and results	• Prior conservative treatments, duration, and response • Treatment plan (i.e., surgical intervention) • Consultation and medical clearance report(s), when applicable • Radiology report(s) and interpretation (i.e., MRI, CT, discogram) • Laboratory results
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	