

<b>Prior Authorization Request Form</b>		<b>Endobronchial Brachytherapy</b>	
BSC Fax: (844) 807-8997		BSC Mail: P.O. Box 629005 El Dorado Hills, CA 95762-9005	
<b>Use AuthAccel - Blue Shield's online authorization system</b> - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit <b>Provider Connection</b> ( <a href="http://www.blueshieldca.com/provider">www.blueshieldca.com/provider</a> ) and click the Authorizations tab to get started.			
<b>Notice: BSC has a 5 Business Day turn-around time on all Prior Authorization Requests.</b> Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.			
<b>Provider Information</b>		<b>Patient Information</b>	
Servicing Provider/Vendor/Lab's Name and Address:		Patient's Name:	
Tax ID Number:	NPI:	Birth Date:	
Referring/Prescribing Physician's Name:		Blue Shield ID Number:	
<input type="checkbox"/> PCP; <input type="checkbox"/> Specialist: PLEASE IDENTIFY SPECIALTY			
Servicing Facility Name and Address:		Place of Service:	
Tax ID Number:	NPI:	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Freestanding Ambulatory Surgery Center <input type="checkbox"/> Patient's Home <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Outpatient Hospital Care <input type="checkbox"/> Long Term Care <input type="checkbox"/> Inpatient Hospital Care <input type="checkbox"/> Other (explain): _____	
Office Contact:		Anticipated Date of Service:	
Phone: (    )			
Fax: (    )			
Please enter all codes requested; "by report" codes must have a description of why the code is being used			
<b>ICD-10 PRIMARY DX CODE:</b>			
<b>ICD-10 ADDITIONAL DX CODE(S):</b>			
<b>CPT/HCPCS CODE(S):</b>			
<b>PATIENT CLINICAL INFORMATION</b>			
<b>Please provide the following documentation:</b> <ul style="list-style-type: none"> <li>• History and physical and/or consultation notes including:               <ul style="list-style-type: none"> <li>○ Tumor classification</li> <li>○ Past medical and/or surgical treatment and response</li> </ul> </li> <li>• Operative report(s) or procedure report(s)</li> <li>• Pathology report(s)</li> <li>• Radiation treatment plan including: type of brachytherapy, therapy schedule, and number of treatments</li> </ul>			

<b>For questions: Call BSC Medical Care Solutions</b>	<b>Phone Number: 1-800-541-6652 Option 6</b>
<small>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 <b>confidentially</b> destroy the information that faxed in error. Thank you for your help in maintaining appropriate confidentiality.</small>	