blue of california

Prior Authorization Request Form	Wireless Capsule Endoscopy for Gastrointestinal (GI) Disorders
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	☐ PH
☐ 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:

SECTION I (COMPLETION COULD RESULT IN QUICKER DETERMINATION)

1. **What is the requested service? (check one):** ☐ Wireless Capsule Endoscopy ☐ Wireless Capsule Endoscopy

2. **Is there suspected small bowel bleeding?** ☐ Yes ☐ No
   If #2 is "Yes," have both upper and lower gastrointestinal endoscopic studies been performed during the current episode of illness and were inconclusive? ☐ Yes ☐ No

3. **Does the member have an initial diagnosis of suspected Crohn disease?** ☐ Yes ☐ No
   If #3 is "Yes," is there evidence of disease on diagnostic tests such as Small-Bowel Follow-Through (SBFT) and upper and lower endoscopy? ☐ Yes ☐ No

4. **Does the member have an established diagnosis of Crohn disease?** ☐ Yes ☐ No
   If #4 is "Yes," are there unexpected change(s) in the course of disease or response to treatment, suggesting the initial diagnosis may be incorrect and re-examination is indicated? ☐ Yes ☐ No

5. **Is the Capsule endoscopy for surveillance of the small bowel in patients with hereditary GI polyposis syndromes, including familial adenomatous polyposis and Peutz-Jeghers syndrome?**
   ☐ Yes ☐ No

SECTION II (COMPLETE THIS SECTION IF QUESTIONS IN SECTION I WERE ANSWERED)

Your signature below indicates the information provided above is true and accurate to the best of your knowledge.

SIGNATURE: _____ DATE: ____/____/_____

SECTION III (REQUIRED FOR ALL REQUESTS)

☐ History and physical and/or consultation notes including:

- ☐ Reason for procedure including suspected or known diagnoses
- ☐ Prior endoscopy or imaging reports if applicable
- ☐ Evidence of anemia (i.e., CBC) or GI bleeding if applicable

Visit our website at blueshieldca.com