blue california
Promise Health Plan

Outpatient Treatment Authorization Request

	Routine Request		Modification/ Extension		Retroactive Request		Urgent Request
FAX: (323) 889-6506		FAX: (323)889-6506		FAX (323)889-6506		FAX: (323) 889-5403	

Important: 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.

Patient Information		**Language spoken:**	
Member's Name:		DOB:	Gender: M F
Street address:	City:	State:	ZIP Code:
Member's plan ID number:		Effective date:	Phone:
Service Information			
Referral requested by:		Phone:	FAX:
Request date:	Referred to (servicing provider):	NPI/Tax ID:	Specialty:
Servicing provider's full address:		Phone:	FAX:
Facility name:	NPI/Tax ID:	Phone:	FAX:
Service(s) Requested:			
Initial consult **Follow-up visits** **Outpatient procedure(s)** **Transportation**			**Other:**
CPT/HCPC code(s):		CPT/HCPC description:	
ICD-10 code(s):		Dx description:	
For modification/extension requests:			
Date last authorized:		Previous Blue Shield Promise authorization number:	
MD/NP/PA justification for request:			
Requesting provider's name (please print):		Provider's signature:	

Accident? Yes No	If yes, where did the accident occur? Home Work Auto Other:	
IPA responsibility? Check box, if yes	IPA authorization number:	Dates of service authorized (from/to): -

PLEASE ATTACH THE LATEST AVAILABLE MEDICAL RECORDS AND PROGRESS NOTES. THIS REFERRAL DOES NOT GUARANTEE ELIGIBILITY. PLEASE CHECK ELIGIBILITY BEFORE RENDERING SERVICE. Payment will not be made for unauthorized services. All lab and x-rays must be ordered/performed by contracted providers. If you are unsure whether the provider is contracted with Blue Shield of California Promise Health Plan, contact Blue Shield Promise's Utilization Management Department at **(800) 468-9935**. Specialist findings must be sent to the member's primary care physician.

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Medi-Cal and Cal MediConnect Physician's Certification Statement

Request for Transportation

This form authorizes the provider of transportation to provide the appropriate level of transportation needed by the Blue Shield of California Promise Health Plan Medi-Cal or Cal MediConnect member.

Member's name:	**Member's plan ID number:**
	Member's date of birth (DOB):

Non-emergency medical transportation (NEMT)	**Non-medical transportation (NMT)**
NEMT includes ambulance, wheelchair and gurney vans, and is provided when it is medically necessary, and the patient is not ambulatory. NEMT under Medi-Cal is covered only when the patients' medical and/or physical condition does not allow them to travel by bus, passenger car, taxicab, or other form of public or private conveyance.	NMT Includes transportation for medically necessary appointments and may be provided via taxi, sedans, or other private conveyance.
Select the type of transportation required:	NEMT NMT

Based on the above information, what type of transportation does the member require?			
NEMT:	Wheelchair	Gurney/stretcher	Ambulance
NMT:	Sedan/Taxi	Private conveyance	

If you have selected NEMT, please describe what is preventing the patient from using non-medical transportation. Failure to complete this section will cause the PCS form to be sent back to the physician for completion.

Will the member use one of the following support aids during the transport?			
Wheelchair	Walker	Cane	Other
If you selected "other," please explain:			

CERTIFICATION: The physician, dentist or podiatrist responsible for providing care for the member is responsible for the determining medical necessity for transportation. This Certificate can be complete and signed by an MD, LVN, RN, PA, NP or discharge planner who is employed or supervised by the hospital, facility or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this Certificate.

Duration of transportation service based on continued health plan eligibility

Dates of service: (maximum 12 months)	Effective date:	End date:

Staff/Physician's signature:		Date:
Staff/Physician's name: (typed or printed)		Title:
Contact phone number:		

Please return this completed and signed form to Blue Shield Promise.

If the member will require NMT Transportation, please send this form using the address or FAX number below:

Postal address:	**FAX number:**
Blue Shield of California Promise Health Plan Attn: Utilization Management 601 Potrero Grande Drive Monterey Park, CA 91755	(323) 889-2105

If the member will require NEMT Transportation, please FAX this form with a Treatment Authorization Request to Utilization Management.

FAX number for standard requests:	**FAX number for urgent requests:**
(323) 889-6506	(323) 889-5403

As a reminder, to qualify as "urgent," the request must meet the following rule:

California Health and Safety Code sections 1367.01(h)(2)

(2) When the enrollee's condition is such that the ***enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function,*** *or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination.*

If you have questions, please contact Blue Shield Promise at (877) 433-2178, 8 a.m. to 5 p.m., Monday through Friday.