BlueCross BlueShield

Federal Employee Program.

Prior Authorization Request Form	*Ambulatory Event Monitors and Mobile Cardiac Outpatient Telemetry*

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.

Referring/Prescribing Provider:	**Patient's First Name:**
Name:	**Patient's Last Name:**
Street Address + Suite#:	**Patient's Date of Birth:**
City, State, Zip:	**ID Number Beginning with "R":**
Tax ID Number: **NPI:**	
Contact Name:	
Phone: ( ) **Fax: ( )**	

Servicing/Billing: Provider/Vendor/Lab	**If Servicing Provider is *billing as part of a Group Contract* enter the Group Name and Address:**
Name:	**Group Name:**
Address + Suite#:	**Group address + Suite#**
City, State, Zip	**City, State, Zip**
Tax ID Number: **NPI:**	**Tax ID Number:** **NPI:**
Contact Name:	
Phone: ( ) **Fax: ( )**	
Type of provider: ☐ PCP; ☐ Specialist Type:	

Billing Facility (If Applicable):	**Place of Service: (Check One Box Only)**
Facility Name:	**☐ Office; ☐ Acute Rehab;**
Street Address	**☐ Ambulance- Air or Water; ☐ Ambulance-Land;**
	☐ Ambulatory Surgical Center;
City, State, Zip	**☐ Assisted Living Facility; ☐ Birthing Center;**
	☐ Custodial Care Facility;
Tax ID Number: **NPI:**	**☐ End Stage Renal Disease Tx; ☐ Group Home;**
	☐ Home; ☐ Hospice; ☐ Independent Clinic;
Contact Name:	**☐ Independent Laboratory; ☐ Inpatient Hospital;**
	☐ Intermediate Care Facility; ☐ IOP;
Phone: ( ) **Fax: ( )**	**☐ IP Psychiatric Facility; ☐ Nursing Facility;**
	☐ Off Campus OP Hosp; ☐ On Campus OP Hosp;
Anticipated Date of Service:	**☐ PHP; ☐ RTC – Psychiatric; ☐ RTC – SUD;**
	☐ Skilled Nursing Facility; ☐ Telehealth;
	☐ Urgent Care 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 CODE(S):

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

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HCPCS CODE(S):

View our Medical Policy on line at https://www.fepblue.org/legal/policies-guidelines

Please provide the following documentation:

History and physical and/or cardiology consultation report including:

- o Clinical justification for device
- o Description of symptoms present and frequency
- o Name and type of device including vendor name
- o Documentation of prior trial of Holter monitor or external ambulatory event monitor
- o History of atrial fibrillation including (if applicable):
  - Past catheter ablation history
  - Anticoagulation status and plan for discontinuation

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