



**BlueCross  
BlueShield**

Federal Employee Program.

<b>Prior Authorization Request Form</b>		<b>Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions</b>	
<p><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 Provider Connection (<a href="http://www.blueshieldca.com/provider">www.blueshieldca.com/provider</a>) and click the Authorizations tab to get started.</p>			
<p><b>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.</b></p>			
<u>Referring/Prescribing Provider:</u> Name:  Street Address + Suite#:  City, State, Zip:  Tax ID Number:                      NPI:  Contact Name:  Phone: (                      )                      Fax: (                      )		Patient's First Name:  Patient's Last Name:  Patient's Date of Birth:  ID Number Beginning with "R":	
<u>Servicing/Billing: Provider/Vendor/Lab</u> Name:  Address + Suite#:  City, State, Zip  Tax ID Number:                      NPI:  Contact Name:  Phone: (                      )                      Fax: (                      )  Type of provider: <input type="checkbox"/> PCP; <input type="checkbox"/> Specialist Type:		If Servicing Provider is <u>billing as part of a Group Contract</u> enter the Group Name and Address: Group Name:  Group address + Suite#  City, State, Zip  Tax ID Number:                      NPI:	
<u>Billing Facility (If Applicable):</u> Facility Name:  Street Address  City, State, Zip  Tax ID Number:                      NPI:  Contact Name:  Phone: (                      )                      Fax: (                      )		<u>Place of Service: (Check One Box Only)</u> <input type="checkbox"/> Office; <input type="checkbox"/> Acute Rehab; <input type="checkbox"/> Ambulance- Air or Water; <input type="checkbox"/> Ambulance-Land; <input type="checkbox"/> Ambulatory Surgical Center; <input type="checkbox"/> Assisted Living Facility; <input type="checkbox"/> Birthing Center; <input type="checkbox"/> Custodial Care Facility; <input type="checkbox"/> End Stage Renal Disease Tx; <input type="checkbox"/> Group Home; <input type="checkbox"/> Home; <input type="checkbox"/> Hospice; <input type="checkbox"/> Independent Clinic; <input type="checkbox"/> Independent Laboratory; <input type="checkbox"/> Inpatient Hospital; <input type="checkbox"/> Intermediate Care Facility; <input type="checkbox"/> IOP; <input type="checkbox"/> IP Psychiatric Facility; <input type="checkbox"/> Nursing Facility; <input type="checkbox"/> Off Campus OP Hosp; <input type="checkbox"/> On Campus OP Hosp; <input type="checkbox"/> PHP; <input type="checkbox"/> RTC – Psychiatric; <input type="checkbox"/> RTC – SUD; <input type="checkbox"/> Skilled Nursing Facility; <input type="checkbox"/> Telehealth; <input type="checkbox"/> Urgent Care Facility; <input type="checkbox"/> Other - Please Specify	
<u>Anticipated Date of Service:</u>			
Please enter all codes requested; <i>unlisted codes must have a description.</i> Please include the quantity for each code requested and if applicable, left, right or bilateral designations.			
<b>ICD-10 CODE(S):</b>			
<b>CPT CODE(S):</b>			

<b>Fax Number: 1-855-895-3504</b>	<b>Phone Number: 1-800-633-4581</b>
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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 consultation notes including:**

- Detailed description of the knee structure (weight-bearing articular cartilage defects [including thickness grade and size dimensions] and Outerbridge grading of surrounding articular cartilage degenerative changes)
- Knee alignment and stability on physical exam
- Documented closure of growth plates (if applicable)
- Prior treatment (surgical and non-surgical) and patient response(s)
- Reason for requested procedure and type of chondrocyte implantation planned (e.g., autologous chondrocyte or matrix-induced)
- Progress notes specific to the condition and request (if applicable)  
Diagnostic radiology reports, especially MRI if available (including Outerbridge classification)
- Other pertinent multidisciplinary notes/reports: (e.g., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management) when applicable

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