BlueCross BlueShield
Federal Employee Program

Prior Authorization Request Form	*Diagnosis and Medical Management of OSA*

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 Physician's Name/Address + Suite#: **Tax ID Number:** **NPI:** **Is the requesting provider a:** ☐ **PCP;** ☐ **Specialist: PLEASE IDENTIFY SPECIALTY** **Phone: ( )** **Fax: ( )**	**Patient's Name:** **Birth Date:** **Member ID Number: R**
Servicing Provider/Vendor/Lab's Name and Address + Suite#: **Tax ID Number:** **NPI:** **Contact:** **Phone: ( )** **Fax: ( )**	**If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:** **Tax ID Number:** **NPI:**
Billing Facility Name and Address (If Applicable): **Tax ID Number:** **NPI:** **Contact:** **Phone: ( )** **Fax: ( )**	**Place of Service:** ☐**Physician's Office** ☐**Freestanding Ambulatory Surgery Center** ☐**Patient's Home** ☐**Home Care Agency** ☐**Outpatient Hospital Care** ☐**Long Term Care** ☐**Inpatient Hospital Care** ☐**Other (explain):** _____ **Anticipated Date of Service:** **Draw Date:**

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):

HCPCS CODE(S):

Please provide the following documentation:

History and physical and/or consultation notes including:

- Weight, height, and neck circumference
- Documentation of obstructive sleep apnea including:
  - AHI/RDI
  - Symptoms
  - Comorbidities
- Type of sleep study that is being requested
- Reason for requested study
- Current treatment plan
- Prior treatment and response (including documented failed trial of CPAP; if applicable)
- Documented sleep test results (e.g., Epworth Sleepiness Scale, Berlin Questionnaire, STOP Bang); if applicable
- Polysomnography or Sleep study reports; if applicable
- Sleep specialty physician recommendation and prescription for positive airway pressure device or intraoral appliance; if applicable

View our Medical Policy on line at https://www.fepblue.org/en/benefit-plans/benefit-plans-brochures-and-forms#

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