

Prior Authorization Request Form		Ambulatory Event Monitors and Mobile Cardiac Outpatient Telemetry	
BSC Fax: (844) 807-8997		BSC Mail: P.O. Box 629005 El Dorado Hills, CA 95762-9005	
<p>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.</p>			
<p>Notice: BSC has a 5 Business Day turn-around time on all Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.</p>			
Provider Information		Patient Information	
Referring/Prescribing Physician: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist* Name: *Please identify SPECIALTY:		Patient's Name: Birth Date: Blue Shield ID Number:	
Servicing Provider: <input type="checkbox"/> MD <input type="checkbox"/> Vendor <input type="checkbox"/> Lab <input type="checkbox"/> Facility <input type="checkbox"/> Other Name: Address: Tax ID Number: NPI:		Place of Service <input type="checkbox"/> Freestanding Ambulatory Surgery Center <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Inpatient Hospital Care <input type="checkbox"/> Long Term Care <input type="checkbox"/> Outpatient Hospital Care <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other (explain): Anticipated Date of Service:	
Office Information: Contact: Phone: () Fax: ()			
Please enter all codes requested; "by report" codes must have a description of why the code is being used			
ICD-10 PRIMARY DX CODE:			
ICD-10 ADDITIONAL DX CODE(S):			
CPT/HCPCS CODE(S):			
PATIENT CLINICAL INFORMATION			
Please provide the following documentation: <ul style="list-style-type: none"> • History and physical and/or consultation notes including: <ul style="list-style-type: none"> ○ Clinical justification for device ○ Description and frequency of symptoms ○ Name and type of device including vendor name ○ Documentation of prior trial of Holter monitor or external ambulatory event monitor if applicable ○ History of AF including (if applicable): <ul style="list-style-type: none"> Past catheter ablation history Anticoagulation status and plan for discontinuation 			

For questions: Call BSC Medical Care Solutions	Phone Number: 1-800-541-6652
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