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| Prior Authorization Request Form | | Bioengineered Skin and Soft Tissue Substitutes | |
| 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 | |
| Office Information: Contact: Phone: () Fax: () | | <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: | |
| 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"> ○ Specific diagnosis requiring skin or breast soft tissue substitute ○ Reason for use, including wound or defect description ○ Previous treatment plan and response ○ Progress notes for the past six months if applicable ○ Exact brand name of skin or soft tissue substitute to be used including amount or number of units needed | | | |

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| For questions: Call BSC Medical Care Solutions | Phone Number: 1-800-541-6652 |
| This facsimile transmission may contain protected and privileged, highly confidential medical, Personal and Health Information (PHI) and/or legal information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate or otherwise distribute it. If you are not the intended recipient, or if you have received this transmission in error, please notify the sender immediately and confidentially destroy the information that faxed in error. Thank you for your help in maintaining appropriate confidentiality. | |