blue of california

Prior Authorization Request Form	Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome
BSC Fax: (844) 807-8997	**BSC Mail:** P.O. Box 629005 El Dorado Hills, CA 95762-9005

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: 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.

Provider Information	Patient Information
Referring/Prescribing Physician: ☐ PCP ☐ Specialist* Name: *Please identify SPECIALTY:	Patient's Name: Birth Date: Blue Shield ID Number:
Servicing Provider: ☐ MD ☐ Vendor ☐ Lab ☐ Facility ☐ Other Name: Address: Tax ID Number: NPI:	**Place of Service** ☐ Freestanding Ambulatory Surgery Center ☐ Home Care Agency ☐ Inpatient Hospital Care ☐ Long Term Care ☐ Outpatient Hospital Care ☐ Patient's Home ☐ Physician's Office ☐ Other (explain): Anticipated Date of Service:
Office Information: Contact: Phone: ( ) Fax: ( )	Select one: CPAP-PURCHASE CPAP-REPLACEMENT NOTE: CPAP Rental does NOT require Prior Authorization

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

See page 2 for requirements

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

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PATIENT CLINICAL INFORMATION

<u>Sleep Studies</u>

Please provide the following documentation:

- Type of sleep study that is being requested
- Reason for requested study
- Completed sleep questionnaires (e.g., Epworth Sleepiness Scale, Berlin Questionnaire, STOP-Bang) if applicable
- Prior Polysomnography or Sleep study reports; if applicable
- Name and type of device used for home sleep study if applicable

<u>CPAP and APAP</u>

Please provide the following documentation:

- History and physical and/or consultation notes including documentation of sleep apnea including:
  - Symptoms
  - Comorbidities
- Prior Polysomnography or Sleep study reports including AHI/RDI/REI
- Prior treatment and response (including documented failed trial of CPAP; if applicable)
- Current treatment plan
- Completed sleep questionnaires (e.g., Epworth Sleepiness Scale, Berlin Questionnaire, STOP-Bang) if applicable
- Completed and signed OSA Oral Appliance Therapy Check-off List by the physician if applicable
- Sleep specialty physician recommendation and prescription for positive airway pressure device or intraoral appliance; if applicable
- If request is for CPAP replacement, please indicate reason
- Name and type of device used for home sleep study if applicable

<u>Intraoral Appliances</u>

Please provide the following documentation:

- History and physical and/or consultation notes including documentation of sleep apnea including:
  - Symptoms
  - Comorbidities
- Prior Polysomnography or Sleep study reports including AHI/RDI/REI
- Prior treatment and response (including documented failed trial of CPAP; if applicable)
- Current treatment plan
- Completed sleep questionnaires (e.g., Epworth Sleepiness Scale, Berlin Questionnaire, STOP-Bang) if applicable
- Completed and signed OSA Oral Appliance Therapy Check-off List by the physician if applicable
- Sleep specialty physician recommendation and prescription for positive airway pressure device or intraoral appliance; if applicable
- If request is for CPAP replacement, please indicate reason
- Name and type of device used for home sleep study if applicable

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

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Obstructive Sleep Apnea Oral Appliance Therapy Check-off List:

Date of pre-authorization request: ______________________________

Name of patient: ______________________________

Blue Shield of California number: ______________________________

The following are a summary of my clinical findings:

1. AHI = 15+: Yes_____No _____
2. RDI = 15+: Yes_____No_____N/A _____
3. ESS = 10+: Yes_____No_____N/A _____
4. AHI or RDI <15 but >=5 with hypertension or ESS >10: Yes:_____ No _____
5. Evidence of periodontal disorder: Yes_____No_____
6. Evidence of temporomandibular disorder: Yes_____No_____
7. Oral appliance is custom-made device by DDS: Yes_____No_____
8. Physician prescription for oral device is attached: Yes_____No_____
9. Acceptable Sleep study attached (less than 5 years old): Yes_____No_____
10. CPAP intolerance (Affidavit) form or statement indicating the patient refuses to use CPAP attached: Yes_____No_____
11. Patient undergoing orthodontic therapy: Yes_____No_____

Explanation/Comments

I hereby certify the information above is true and accurate to the best of my clinical knowledge at the time of my clinical examination:

Signature:______________________________Date: ______________________

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