

<b>Prior Authorization Request Form</b>		<b>Genetic Testing for Cardiac Ion Channelopathies</b>	
BSC Fax: (844) 807-8997		BSC Mail: P.O. Box 629005 El Dorado Hills, CA 95762-9005	
<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.			
<b>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.</b>			
<b>Provider Information</b>		<b>Patient Information</b>	
<b>Referring/Prescribing Physician:</b> <input type="checkbox"/> PCP <input type="checkbox"/> Specialist* <b>Name:</b> <b>*Please identify SPECIALTY:</b>		<b>Patient's Name:</b>  <b>Birth Date:</b>  <b>Blue Shield ID Number:</b>	
<b>Servicing Provider:</b> <input type="checkbox"/> MD <input type="checkbox"/> Vendor <input type="checkbox"/> Lab <input type="checkbox"/> Facility <input type="checkbox"/> Other <b>Name:</b> <b>Address:</b> <b>Tax ID Number:</b> <b>NPI:</b>		<b>Place of Service</b> <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): <b>Anticipated Date of Service:</b>	
<b>Office Information:</b> <b>Contact:</b> <b>Phone:</b> (     ) <b>Fax:</b> (     )			
<b>Please enter all codes requested; "by report" codes must have a description of why the code is being used</b>			
<b>ICD-10 PRIMARY DX CODE:</b>			
<b>ICD-10 ADDITIONAL DX CODE(S):</b>			
<b>CPT/HCPCS CODE(S):</b>			
<b>PATIENT CLINICAL INFORMATION</b>			
<b>Please provide the following documentation:</b> <ul style="list-style-type: none"> <li>• History and physical and/or cardiology consultation notes including:             <ul style="list-style-type: none"> <li>○ Syndrome that is being tested and clinical justification for testing</li> <li>○ Description of signs and symptoms</li> <li>○ Schwartz score (if applicable)</li> <li>○ Cardiac testing results (e.g., electrocardiogram, holter or event monitor report)</li> <li>○ Family history specific to long QT syndrome, Brugada syndrome, Catecholaminergic Polymorphic Ventricular Tachycardia, or short QT syndrome, including relationship to patient</li> </ul> </li> </ul> <p>Name of the test being requested or the Concert Genetics GTU identifier:</p> <p>The Concert Genetics GTU can be found at <a href="https://app.concertgenetics.com">https://app.concertgenetics.com</a></p>			

<b>For questions: Call BSC Medical Care Solutions</b>	<b>Phone Number: 1-800-541-6652</b>
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