blue of california

| Prior Authorization Request Form | Genetic Testing for Cardiac Ion Channelopathies |
|---|---|
| **Standard Fax Number:** 1 (844) 807-8997 | **Urgent Fax Number:** 1 (844) 807-8996 |

**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: Blue Shield of CA has a 5 Business Day turn-around time on all Standard Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.**

☐ New Standard Request ☐ New Urgent Request ☐ Standing Referral

**Important For Urgent Requests:** Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. ***If there is no MD signature present the request will be processed as a Standard request.***

***MD Signature REQUIRED For Urgent Requests Only:***

☐ **Modification Or** ☐ **Extension Requests Complete the Section Below:**

| Date Last Authorized: | Previous Authorization Number: |
|---|---|
| MD/NP/PA justification for modification or extension: | |

**Patient Information:**

| First Name: | Last Name: |
|---|---|
| Date of Birth: | ID Number: |
| Address: | |

**Referring/Prescribing Provider:**

| Name: | | | NPI: | |
|---|---|---|---|---|
| Street Address + Suite #: | | | | |
| City: | State: | Zip: | Phone: | Fax: |
| Type of Provider: ☐ PCP ☐ Specialist Type: | | | Contact Name and Phone Number: | |

**Servicing/Billing: Provider/Vendor/Lab** ***If same as Referring/Prescribing Provider Check Here*** ☐

| Name: | Tax ID: | NPI: |
|---|---|---|
| Street Address + Suite #: | | |

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| City: | State: | Zip: | Phone: | Fax: |
|---|---|---|---|---|
| Specialist Type: | | | Contact Name and Phone Number: | |

**If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:**

| Group Name: | | NPI: |
|---|---|---|
| Street Address + Suite #: | | |
| City: | State: | Zip: |

**Billing Facility (If Applicable):**

| Facility Name: | | NPI: | |
|---|---|---|---|
| Street Address + Suite #: | | | |
| City: | State: | Zip: | Phone: | Fax: |
| Contact Name and Phone Number: | | | |

| **Anticipated Date of Service:** | **If Lab, Draw Date:** |
|---|---|

**Place of Service: (Check One Box Only or If typing replace box with an "X"):**

| | | |
|---|---|---|
| ☐ Office | ☐ Home | ☐ On Campus OP Hosp |
| ☐ Acute Rehab | ☐ Hospice | ☐ PHP |
| ☐ Ambulance- Air or Water | ☐ Independent Clinic | ☐ RTC – Psychiatric |
| ☐ Ambulance-Land | ☐ Independent Laboratory | ☐ RTC – SUD |
| ☐ Ambulatory Surgical Center | ☐ Inpatient Hospital | ☐ Skilled Nursing Facility |
| ☐ Assisted Living Facility | ☐ Intermediate Care Facility | ☐ Telehealth |
| ☐ Birthing Center | ☐ IOP | ☐ Urgent Care Facility |
| ☐ Custodial Care Facility | ☐ IP Psychiatric Facility | ☐ Other - Please Specify: |
| ☐ End Stage Renal Disease Tx | ☐ Nursing Facility | |
| ☐ Group Home | ☐ Off Campus OP Hosp | |

**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/HCPC Code(s):

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

| Please provide the following documentation: |
| --- |
| ☐ History and physical and/or cardiology consultation notes including:<br>☐ Syndrome that is being tested and clinical justification for testing<br>☐ Description of signs and symptoms<br>☐ Schwartz score (if applicable)<br>☐ Cardiac testing results (e.g., electrocardiogram, holter or event monitor report)<br>☐ Family history specific to long QT syndrome, Brugada syndrome, Catecholaminergic Polymorphic Ventricular Tachycardia, or short QT syndrome, including relationship to patient<br><br>Name of the test being requested or the Concert Genetics GTU identifier<br><br>The Concert Genetics GTU can be found at https://app.concertgenetics.com |
| Visit our website at blueshieldca.com |