

<b>Prior Authorization Request Form</b>		<b>Genetic Testing for Developmental Delay/Intellectual Disability, Autism Spectrum Disorder, and Congenital Anomalies</b>	
BSC Fax: (844) 807-8997		BSC Mail: P.O. Box 629005 El Dorado Hills, CA 95762-9005	
<p><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 <a href="http://www.blueshieldca.com/provider">Provider Connection (www.blueshieldca.com/provider)</a> and click the Authorizations tab to get started.</p>			
<p><b>Notice: BSC has a 5 Business Day turn-around time on all Prior Authorization Requests.</b> Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.</p>			
<b>Provider Information</b>		<b>Patient Information</b>	
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:		<b>Place of Service</b>	
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			
<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>			
<p><b>Please provide the following documentation:</b></p> <ul style="list-style-type: none"> <li>History and physical and/or consultation notes including:                             <ul style="list-style-type: none"> <li>Birth records (if applicable)</li> <li>Diagnosis</li> <li>Genetic counseling notes (if applicable)</li> <li>Treatment plan (if applicable)</li> </ul> </li> <li>Specific test(s) requested</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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