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Prior Authorization Request Form

(Please choose the appropriate policy for this request)

☐ **Gender Affirmation Surgery**

☐ **Orthognathic Surgery**

☐ **Reconstructive Services**

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: ( )**	

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

☐ Gender Affirmation Surgery

Please provide the following documentation:
For Mastectomy, Subcutaneous Mastectomy, Breast Reduction Surgeries*:

- ☐ Age 18 or older
- ☐ DSM-5 diagnosis of gender dysphoria
- ☐ Any other medical/mental health conditions present are well-controlled
- ☐ One letter of support from a mental health professional who monitored the patient throughout psychotherapy
- ☐ Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

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

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For Hysterectomy and Salpingo-Oophrectomy Surgeries*:

- ☐ Age 18 or older
- ☐ DSM-5 diagnosis of gender dysphoria
- ☐ Any other medical/mental health conditions present are well-controlled
- ☐ Twelve months of continuous hormone therapy or reason patient is unable to take hormones
- ☐ Two letters of support from different mental health professionals (one from the patient's psychotherapist and one that is only evaluating for surgery)
- ☐ Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

For Genital Reconstructive Surgeries*:

- ☐ Age 18 or older
- ☐ DSM-5 diagnosis of gender dysphoria
- ☐ Any other medical/mental health conditions present are well-controlled
- ☐ Twelve months of continuous hormone therapy or reason patient is unable to take hormones
- ☐ Two letters of support from different mental health professionals (one from the patient's psychotherapist and one that is only evaluating for surgery)
- ☐ Lived and worked in the desired gender role continuously for 12 months
- ☐ Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

Other Related Procedures

- ☐ Documentation (e.g., quality color photographs) clearly showing the extent of the characteristics proposed for further treatment that are outside the range of normal for the preferred gender (except for electrolysis of the pubic area, including the arm or similar region if needed prior to being used as a graft site).
- ☐ Documentation from an endocrinologist or medical provider with experience in providing hormonal therapy stating that maximal appropriate hormonal therapy has been used for at least 2 years (may include the time prior to other procedures as appropriate). Documentation should include regular clinical evaluations for response (including laboratory monitoring at least twice a year) to sex steroid hormones.
- ☐ Current (updated after any prior surgery or other treatments for gender dysphoria) documentation from a qualified mental health professional that DSM-5 criteria for gender dysphoria is present and directly related to the treatment requested.
- ☐ For voice retraining therapy or voice modification surgery, a recommendation from a speech therapist outlining the need (including whether the patient's vocal characteristics are currently outside the range of normal for the preferred gender) and treatment plan. If voice modification surgery is requested, documentation that a trial of speech therapy was tried and failed first and that surgery is likely to provide further benefit must also be submitted.
- ☐ Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

*Please refer to the Medical Policy Statement/Medical Policy Guidelines for specific details regarding requested documentation.

PATIENT CLINICAL INFORMATION

☐ Orthognathic Surgery

Please provide the following documentation:

- ☐ History and physical and/or consultation notes including:
- ☐ Description and cause of the specific anatomic deformity present
- ☐ Diagnosis and evaluation
- ☐ Previous management of the functional medical impairment (if applicable)
- ☐ Symptoms related to the orthognathic deformity (if applicable)

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- ☐ Diagnostic quality (clear) intra-oral and extra-oral photographs, two-view head photograph (front and side view)
- ☐ Bilateral cephalometric radiographs with measurements
- ☐ Cephalometric tracings and/or analysis
- ☐ Additional reports:
- ☐ Current study models with the appropriate bite registration or representation of patient's pre-surgical centric occlusion and /or centric relation bite
- ☐ Panorex x-ray or tomograms
- ☐ Documentation demonstrating completion of skeletal growth for cases under the age of 18 (except for Class II malocclusion-mandibular retrognathic)
- ☐ Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

PATIENT CLINICAL INFORMATION

☐ **Reconstructive Services**

Please provide the following documentation:

- ☐ History and physical and/or consultation notes including:
  - ☐ Clinical indications for procedure/surgery
  - ☐ Documentation of any functional problems or limitations to be corrected by the procedure including the cause of the issue
  - ☐ Previous treatment(s) and response(s) (if applicable)
  - ☐ Proposed procedural treatment plan
- ☐ Office note(s) pertaining to the clinical problem and medical necessity of the procedure requested
- ☐ Quality color photographs which accurately depicts the extent of the clinical problem (as applicable)
- ☐ Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.