

<b>Prior Authorization Request Form</b>		<b>Genetic Testing for Mitochondrial Disorders</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.</b> Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.			
<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>			
<b>Please provide the following documentation:</b> <ul style="list-style-type: none"> <li>• History and physical and/or consultation notes including:             <ul style="list-style-type: none"> <li>o Clinical findings (i.e., pertinent symptoms and duration)</li> <li>o Comorbidities</li> <li>o Activity and functional limitations</li> <li>o Family history if applicable</li> <li>o Reason for procedure/test/device, when applicable</li> <li>o Pertinent past procedural and surgical history</li> <li>o Past and present diagnostic testing and results as applicable</li> <li>o Prior conservative treatments, duration, and response</li> <li>o Treatment plan (i.e., surgical intervention) if applicable</li> </ul> </li> <li>• Consultation and medical clearance report(s), when applicable</li> <li>• Radiology report(s) and interpretation (i.e., MRI, CT, discogram)</li> <li>• Laboratory results</li> <li>• Other pertinent multidisciplinary notes/reports: (e.g., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management) when applicable</li> <li>• Name of the test being requested or the Concert Genetics GTU identifier:</li> </ul> <p style="text-align: center;">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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