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Prior Authorization Request Form	Hysterectomy Surgery for Benign Conditions
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 #:		

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

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PATIENT CLINICAL INFORMATION

Please provide the following documentation:

- ☐ Completed Hysterectomy Decision Aid (https://www.blueshieldca.com/provider/authorizations/forms- lists/forms.sp) – see survey below: page 4
- ☐ Completed CollaboRATE survey – see survey below: page 5

NOTE:
The above two surveys are to be filled out and signed by the PATIENT and submitted with the documentation below.

Please provide the following documentation:

- ☐ History and physical and/or consultation notes including:
  - ☐ Reason for surgical intervention (malignant or non-malignant indications)such as abnormal uterine bleeding, adenomyosis, pain, etc.)
- ☐ Prior conservative treatments, duration, and response including but not limited to those the patient:
  - ☐ Has tried (and results)
  - ☐ Has not tolerated
  - ☐ Has a contraindication to
  - ☐ Has declined (Note: If the patient has declined less invasive alternatives to hysterectomy the rationale must be documented.)
- ☐ Past and present diagnostic testing and results
- ☐ Pertinent past procedural and surgical history
- ☐ Radiology report(s) (i.e., MRI, CT, US)
- ☐ Completed and signed Hysterectomy Decision Aid by the member
- ☐ Completed and signed CollaboRATE survey by the member

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

Let's Talk Hysterectomy

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One of the most important factors in helping you choose appropriate medical care is your comprehensive understanding of the reasons for treatment, the risks, and the potential benefits. If hysterectomy has been suggested to you as an option for your particular problem, you should carefully weigh the pros and cons, the alternative treatments, and the potential benefits and risks.

Should You Have a Hysterectomy?

Talk to your doctor and become an active partner in making an informed decision about whether hysterectomy is right for you.

- How will a hysterectomy help me?
- What are my other treatment options?
- What are the risks of each of my options?
- What are the short & long term risks or side effects?
- Why might this treatment not be right for me?
- If I don't have surgery will my condition worsen?

Risks and Complications

Risks and complications will depend on your medical condition, age and experience of your surgeon, but risks may include:

- Anesthesia problems, such as breathing or heart problems
- Early menopause, if the ovaries are removed
- Surgery may not correct pelvic pain
- Injury to nearby organs
- Blood clots in the legs or lungs
- Infection
- Heavy bleeding
- Pain during sexual intercourse

The Procedure

4 types of hysterectomy

1. **Vaginal hysterectomy (VH)**

   Decision points: Minimally invasive, fast recovery (2 weeks), less pain, no external scaring

2. **Laparoscopic hysterectomy (TLH, LSH, LAVH)**

   Decision points: Minimal pain & scarring, fast recovery (2 weeks), less pain, higher risk of complications

3. **Abdominal hysterectomy (AH)**

   Decision points: Invasive procedure, longer recovery time (4-6 weeks), bigger scar, higher risk of complications

4. **Robotic hysterectomy (RH)**

   Decision points: Technique dependent, investigational in certain conditions, fast recovery (2 weeks)

These websites offer more information:

www.aagl.org / www.acog.org / www.hysterectomyoptions.com / www.hystersisters.com

Your Decision

Hysterectomies are performed to treat many conditions. Be sure you understand the nature of your condition and how hysterectomy would treat it.

Top reasons for a hysterectomy and the alternatives

Fibroids
- Doing nothing – fibroids tend to shrink on their own after menopause
- Surgical removal (myomectomy)
- Radio frequency ablation
- Cutting off blood flow to fibroids
- Drug therapy

Endometriosis
- Surgical removal of scar tissue & endometrial implants by laparoscopic surgery
- Drug therapy

Abnormal Uterine Bleeding
- Progesterone containing IUD
- Endometrial lining removal
- Hormone or drug therapy
- Other treatments depending on the cause

Shared Decision

Please check each box

A. Do you understand the options available to you? Yes ☐ No ☐

B. Are you clear about which benefits and side effects matter most to you? Yes ☐ No ☐

C. Do you have enough information to make an informed choice? Yes ☐ No ☐

D. Do you feel comfortable about your decision? Yes ☐ No ☐

Your signature ensures you feel confident that you and your doctor have explored all of your options and you understand everything fully and that together you are making the decision that is best for you. This Decision Aid does not replace the need for a signed Informed Consent for treatment form that is required by law in many states.

Patient Signature:_____
Date:____/____/_____

Physician Signature:_____
Date:____/____/_____

Information compiled from: Centers for Disease Control and Prevention, National Women's Health Network, Office on Women's Health, U.S. Department of Health and Human Services, The American Congress of Obstetricians and Gynecologists, The Cleveland Clinic Foundation & Healthwise Inc.

collaboRATE™

Thinking about the appointment you have just had ...

1. How much effort was made to help you understand your health issues?

0	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○
No effort was made									Every effort was made

2. How much effort was made to listen to the things that matter most to you about your health issues?

0	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○
No effort was made									Every effort was made

3. How much effort was made to include what matters most to you in choosing what to do next?

0	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○
No effort was made									Every effort was made

Your signature ensures you feel confident that you and your doctor have explored all of your options and you understand everything fully and that together you are making the decision that is best for you.

Patient Signature:_____ Date:____/____/____