blue of california

Prior Authorization Request Form	Knee Arthroplasty for Adults
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

Please provide ALL of the following documentation:

- ☐ **Completed Knee Injury & Osteoarthritis Outcome Score (KOOS), Jr.** – see survey below: page 2
- ☐ **Completed CollaboRATE survey** – see survey below: page 3

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

- ☐ History and physical and/or consultation notes including:
  - ☐ Clinical records indicating pain and functional disability that interferes with ADLs
  - ☐ Documentation of limited range of motion
  - ☐ Reason for surgical intervention
  - ☐ Treatment plan (i.e., surgical intervention)
- ☐ Prior conservative treatments, duration, and response
- ☐ Past and present diagnostic testing and results
- ☐ Pertinent past procedural and surgical history
- ☐ Radiology report(s) (i.e., MRI, CT) used to make surgical decision

An Independent Member of the Blue Shield Association

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

KOOS Jr. Knee Survey

Instructions: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to do your usual activities.

Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Stiffness

The following question concerns the amount of joint stiffness you have experienced during the last week in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

1. How severe is your knee stiffness after first wakening in the morning?

None	Mild	Moderate	Severe	Extreme
○	○	○	○	○

Pain

What amount of knee pain have you experienced the **last week** during the following activities?

2. Twisting/pivoting on your knee

None	Mild	Moderate	Severe	Extreme
○	○	○	○	○

3. Straightening knee fully

None	Mild	Moderate	Severe	Extreme
○	○	○	○	○

4. Going up or down stairs

None	Mild	Moderate	Severe	Extreme
○	○	○	○	○

5. Standing upright

None	Mild	Moderate	Severe	Extreme
○	○	○	○	○

Function, daily living

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

6. Rising from sitting

None	Mild	Moderate	Severe	Extreme
○	○	○	○	○

7. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
○	○	○	○	○

Patient Signature:_____ **Date:**_____/_____/_____

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:____/____/____