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Prior Authorization Request Form

(Please choose the appropriate policy for this request)

☐ **Microwave and Locoregional Laser Tumor Ablation**

☐ **Radiofrequency Ablation of Primary or Metastatic Liver Tumors**

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

☐ **Microwave and Locoregional Laser Tumor Ablation**

Please provide the following documentation:

☐ History and physical and/or consultation notes including:
- ☐ Clinical indications/justification of procedure
- ☐ Eastern Cooperative Oncology Group functional status (if applicable)
- ☐ Previous treatment(s), duration and response(s)
- ☐ Treatment Plan
- ☐ Tumor type and description (i.e., resectable or unresectable, primary or metastatic, tumor burden [e.g., liver dominant])

☐ Pertinent radiological imaging results (i.e., abdominal CT and/or MRI and/or PET)

☐ Pathology report including tumor node metastasis (TNM) classification

☐ Current serum chemistry, liver function tests, and tumor marker results

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

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PATIENT CLINICAL INFORMATION

☐ Radiofrequency Ablation of Primary or Metastatic Liver Tumors

Please provide the following documentation:

- ☐ History and physical and/or consultation notes including:
  - ☐ Clinical indications/justification of procedure
  - ☐ Eastern Cooperative Oncology Group functional status (if applicable)
  - ☐ Previous treatment(s), duration and response(s)
  - ☐ Treatment Plan
  - ☐ Tumor type and description (i.e., resectable or unresectable, primary or metastatic, tumor burden [e.g., liver dominant])
  - ☐ Number of location of tumors to be treated
- ☐ Pertinent radiological imaging results (i.e., abdominal CT and/or MRI and/or PET)
- ☐ Pathology report including tumor node metastasis (TNM) classification
- ☐ Current serum chemistry, liver function tests, and tumor marker results