

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 \(www.blueshieldca.com/provider\)](http://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: <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:	<table border="1"> <thead> <tr> <th>Place of Service</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Freestanding Ambulatory Surgery Center</td></tr> <tr><td><input type="checkbox"/> Home Care Agency</td></tr> <tr><td><input type="checkbox"/> Inpatient Hospital Care</td></tr> <tr><td><input type="checkbox"/> Long Term Care</td></tr> <tr><td><input type="checkbox"/> Outpatient Hospital Care</td></tr> <tr><td><input type="checkbox"/> Patient's Home</td></tr> <tr><td><input type="checkbox"/> Physician's Office</td></tr> <tr><td><input type="checkbox"/> Other (explain):</td></tr> <tr><td>Anticipated Date of Service:</td></tr> </tbody> </table>	Place of Service	<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:
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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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 - Treatment Plan
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 - 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
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