

<b>Prior Authorization Request Form</b>		<b>Noninvasive Techniques for the Evaluation and Monitoring of Patients With Chronic Liver Disease</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 <a href="http://www.blueshieldca.com/provider">Provider Connection (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. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.</b>			
<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> <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:	
Office Information: Contact: Phone: (    ) Fax: (    )			
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>			
Please provide the following documentation: <ul style="list-style-type: none"> <li>• History and physical and/or consultation notes including:               <ul style="list-style-type: none"> <li>○ Laboratory report including: specific name and test requested</li> <li>○ Reason for testing including if this request is for initial evaluation or for ongoing monitoring</li> </ul> </li> </ul>			

<b>For questions: Call BSC Medical Care Solutions</b>	<b>Phone Number: 1-800-541-6652</b>
<small>This facsimile transmission may contain protected and privileged, highly confidential medical, Personal and Health Information (PHI) and/or legal information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate or otherwise distribute it. If you are not the intended recipient, or if you have received this transmission in error, please notify the sender immediately and <b>confidentially</b> destroy the information that faxed in error. Thank you for your help in maintaining appropriate confidentiality.</small>	