blue of california

Prior Authorization Request Form	Power Wheelchairs and Power Operated Vehicles for Permanent Use
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 the following documentation:

- ☐ History and physical and/or consultation notes including:
  - ☐ Diagnosis and any applicable comorbidities
  - ☐ Specialty evaluation by a PT, OT, or MD
  - ☐ Patient's ability to operate PWC or POV
  - ☐ Limitations or medical diagnoses supporting the need for addons such as power tilt/ recline or both, power elevating leg rests, drive control interface, etc., as applicable
- ☐ Written prescription from the physician indicating that the anticipated need for the PWC or POV is 6 months or greater
- ☐ The DME supplier must submit all HCPCS codes, narrative description of the HCPCS code (particularly for non-specific codes), rationale for the request, and suppliers charge
- ☐ Request for new PWC or PVC or replacement
- ☐ Reason device can't be repaired if replacement request
- ☐ Caregiver status
- ☐ Mobility assessment by a certified therapist or the physician including the patient's mobility limitations
- ☐ Detailed product description including manufacturer, make, and model

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