

Prior Authorization Request Form		Reconstructive Breast Surgery/Management of Breast Implants		
Standard Fax Number: 1 (844) 807-8997		Urgent Fax Number: 1(844) 807-8996		
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: Blue Shield of CA has a 5 Business Day turn-around time on all Standard Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.				
<input type="checkbox"/> New Standard Request		<input type="checkbox"/> New Urgent Request		<input type="checkbox"/> Standing Referral
Important For Urgent Requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. <i>If there is no MD signature present the request will be processed as a Standard request.</i>				
MD Signature REQUIRED For Urgent Requests Only:				
<input type="checkbox"/> Modification Or <input type="checkbox"/> Extension Requests Complete the Section Below:				
Date Last Authorized:		Previous Authorization Number:		
MD/NP/PA justification for modification or extension:				
Patient Information:				
First Name:		Last Name:		
Date of Birth:		ID Number:		
Address:				
Referring/Prescribing Provider:				
Name:		NPI:		
Street Address + Suite #:				
City:	State:	Zip:	Phone:	Fax:
Type of Provider: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist Type:			Contact Name and Phone Number:	
Servicing/Billing: Provider/Vendor/Lab		<i>If same as Referring/Prescribing Provider Check Here</i> <input type="checkbox"/>		
Name:		Tax ID:		NPI:
Street Address + Suite #:				

City:	State:	Zip:	Phone:	Fax:
Specialist Type:			Contact Name and Phone Number:	
If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:				
Group Name:			NPI:	
Street Address + Suite #:				
City:		State:		Zip:
Billing Facility (If Applicable):				
Facility Name:			NPI:	
Street Address + Suite #:				
City:		State:		Zip:
City:		State:		Zip:
Contact Name and Phone Number:			Fax:	
Anticipated Date of Service:			If Lab, Draw Date:	
Place of Service: (Check One Box Only or If typing replace box with an "X"):				
<input type="checkbox"/> Office	<input type="checkbox"/> Home	<input type="checkbox"/> On Campus OP Hosp		
<input type="checkbox"/> Acute Rehab	<input type="checkbox"/> Hospice	<input type="checkbox"/> PHP		
<input type="checkbox"/> Ambulance- Air or Water	<input type="checkbox"/> Independent Clinic	<input type="checkbox"/> RTC – Psychiatric		
<input type="checkbox"/> Ambulance-Land	<input type="checkbox"/> Independent Laboratory	<input type="checkbox"/> RTC – SUD		
<input type="checkbox"/> Ambulatory Surgical Center	<input type="checkbox"/> Inpatient Hospital	<input type="checkbox"/> Skilled Nursing Facility		
<input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Intermediate Care Facility	<input type="checkbox"/> Telehealth		
<input type="checkbox"/> Birthing Center	<input type="checkbox"/> IOP	<input type="checkbox"/> Urgent Care Facility		
<input type="checkbox"/> Custodial Care Facility	<input type="checkbox"/> IP Psychiatric Facility	<input type="checkbox"/> Other - Please Specify:		
<input type="checkbox"/> End Stage Renal Disease Tx	<input type="checkbox"/> Nursing Facility			
<input type="checkbox"/> Group Home	<input type="checkbox"/> Off Campus OP Hosp			
Please enter all codes requested; unlisted codes must have a description.				
Please include the quantity for each code requested and if applicable, left, right or bilateral designations.				
ICD-10 Code(s):				
CPT/HCPC Code(s):				
For questions: Call BSC Medical Care Solutions Phone Number: 1-800-541-6652				

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Please provide the following documentation:

- History and physical and/or consultation notes including:
 - Clinical indication for removal including Baker class if applicable
 - Reason for original insertion of the breast implant
 - Type of implant being removed
- Operative report(s) (if applicable)
- Radiological reports (if applicable)
- Any high-quality color images should be securely emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

Visit our website at blueshieldca.com