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Prior Authorization Request Form

(Please choose the appropriate policy for this request)

☐ **Reduction Mammaplasty**

☐ **Surgical Treatment of Gynecomastia**

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

☐ Reduction Mammaplasty

Please provide the following documentation:

- ☐ History and physical and/or consultation notes including:
  - ☐ Pain symptoms and duration
  - ☐ Documented intertrigo and duration, if applicable
  - ☐ Conservative treatment(s) duration and response
- ☐ 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.

☐ Surgical Treatment of Gynecomastia

Please provide the following documentation:

- ☐ History and physical and/or consultation notes including:
  - ☐ Duration of condition, prior treatment and response(s)
- ☐ Lab and/or pathology reports (if applicable)

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

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- ☐ Mammography or radiological reports (if applicable)
- ☐ Quality medical photographs (anterior and lateral views) substantiating the request for surgery
- ☐ 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.

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