blue of california

Prior Authorization Request Form	Subtalar Arthroereisis
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:
  - ☐ Clinical findings (i.e., pertinent symptoms and duration)
  - ☐ Comorbidities
  - ☐ Activity and functional limitations
  - ☐ Family history if applicable
  - ☐ Reason for procedure/test/device, when applicable
  - ☐ Pertinent past procedural and surgical history
  - ☐ Past and present diagnostic testing and results
  - ☐ Prior conservative treatments, duration, and response
  - ☐ Treatment plan (i.e., surgical intervention)
- ☐ Consultation and medical clearance report(s), when applicable
- ☐ Radiology report(s) and interpretation (i.e., MRI, CT, discogram)
- ☐ Laboratory results
- ☐ Other pertinent multidisciplinary notes/reports: (e.g., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management) when 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.

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