

Prior Authorization Request Form		Subtalar Arthroereisis	
BSC Fax: (844) 807-8997		BSC Mail: P.O. Box 629005 El Dorado Hills, CA 95762-9005	
<p>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.</p>			
<p>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.</p>			
Provider Information		Patient Information	
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:		Place of Service	
Office Information: Contact: Phone: () Fax: ()		<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:	
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: <ul style="list-style-type: none"> • History and physical and/or consultation notes including: <ul style="list-style-type: none"> ○ 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. 			

An Independent Member of the Blue Shield Association

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