

**Urgent Request for Prior Authorization**

**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](http://www.blueshieldca.com/provider)) and click the Authorizations tab to get started.

Please note, scheduling issues do not meet the definition of Urgent.

**Definition of an Urgent Request:**

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 member.

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:	<b>Place of Service</b> <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:
Office Information: Contact: Phone: (     )     ) Fax: (     )     )	

**Information required below**

**Please provide the necessary clinical information along with the procedure fax form.**  
**Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. Please be advised the request will take up to and including 72 hours.**

Surgery/procedure/Diagnosis Code request:  
 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):**

PLEASE EXPLAIN THE REASON FOR THE EXPEDITED REQUEST TO SUPPORT THE DEFINITION INDICATED ABOVE.

**MD SIGNATURE: \_\_\_\_\_ PLEASE FAX TO BSC: 844-807-8996**

**FOR BLUE SHIELD OF CALIFORNIA USE ONLY:**

REQUEST DOES MEET THE URGENT CRITERIA. PLEASE ALLOW 72 HOURS FROM THE ORIGINAL RECEIPT DATE FOR A RESPONSE.

REQUEST DOES NOT MEET THE URGENT CRITERIA. PLEASE ALLOW 5 BUSINESS DAYS FROM THE ORIGINAL RECEIPT DATE OF THE REQUEST FOR A RESPONSE.

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

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