

Prior Authorization Request and Questionnaire Form	Wireless Capsule Endoscopy for Gastrointestinal (GI) Disorders
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: <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 <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: ()	
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):	
SECTION I (COMPLETION COULD RESULT IN QUICKER DETERMINATION)	
1. What is the requested service? (check one): Wireless Capsule Endoscopy Patency Capsule	
2. Is there suspected small bowel bleeding? Yes No If #2 is "Yes," have <u>both</u> upper and lower gastrointestinal endoscopic studies been performed during the current episode of illness and were <u>inconclusive</u> ? Yes No	
3. Does the member have an initial diagnosis of suspected Crohn disease? Yes No If #3 is "Yes," is there <u>evidence of disease</u> on diagnostic tests such as Small-Bowel Follow-Through (SBFT) and upper and lower endoscopy? Yes No	
4. Does the member have an established diagnosis of Crohn disease? Yes No If #4 is "Yes," are there <u>unexpected change(s)</u> in the course of disease or response to treatment, suggesting the initial diagnosis may be incorrect and re-examination is indicated? Yes No	
5. Is the Capsule endoscopy for surveillance of the small bowel in patients with hereditary GI polyposis syndromes, including familial adenomatous polyposis and Peutz-Jeghers syndrome? Yes No	

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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SECTION II (COMPLETE THIS SECTION IF QUESTIONS IN SECTION I WERE ANSWERED)

Your signature below indicates the information provided above is true and accurate to the best of your knowledge.

SIGNATURE: _____ DATE: _____ / ____ / ____

SECTION III (REQUIRED FOR ALL REQUESTS)

Please provide the following documentation (as well as any other relevant clinical information):

- History and physical and/or consultation notes including:
 - Reason for procedure including suspected or known diagnoses
 - Prior endoscopy or imaging reports if applicable
 - Evidence of anemia (i.e., CBC) GI bleeding if applicable

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