blue CALIFORNIA

PROMISE

Treatment Authorization Request	**Generic (No Policy Available)** **Service Requested:**
Standard Fax Number: (323) 889-6506	**Urgent Fax Number:** (323) 889-5403

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: Blue Shield of CA Promise Health Plan has a 5 Business Day turn-around time on all Standard Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

☐ **New Standard Request** ☐ **New Urgent Request** ☐ **Retro Request** ☐ **Standing Referral**

Important For Urgent Requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is 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 enrollee.***If there is no MD signature present, the request will be processed as a Standard request.***

The following type of service should be faxed to the Urgent Fax number (above) to meet regulatory timeliness standards: **Therapeutic Enteral Formula

MD Signature REQUIRED For Urgent Requests Only:

☐ **Modification Or** ☐ **Extension Requests Complete the Section Below:**

Date Last Authorized:	Previous Authorization Number:
MD/NP/PA justification for modification or extension:	

Patient Information:

First Name:	Last Name:
Date of Birth:	Blue Shield of California Promise ID Number:
Street Address:	

City:	State:	Zip Code:

Referring/Prescribing Provider:

Name:	Tax ID:	NPI:
Street Address + Suite#:		

City:	State:	Zip Code:

Phone:	Fax:
Type of Provider: ☐ PCP ☐ Specialist	Specialist Type (if applicable):
Contact Name and Phone Number:	

Servicing/Billing: Provider/Vendor/Lab ***If same as Referring/Prescribing Provider, Check Here*** ☐

Name:	Tax ID:	NPI:

Street Address + Suite#:		
City:	State:	Zip Code:
Phone:	Fax:	
Specialist Type:		
Contact Name and Phone Number:		

If Servicing Provider is billing as part of a Group Contract, enter the Group information below:		
Group Name:	Tax ID:	NPI:
Street Address + Suite#:		
City:	State:	Zip Code:

Billing Facility (If Applicable):		
Facility Name	Tax ID:	NPI:
Street Address + Suite#:		
City:	State:	Zip Code:
Phone:	Fax:	
Contact Name and Phone Number:		

Anticipated Date of Service:	**If Lab, Draw Date:**

Place of Service: (Check one box only):

☐ Office	☐ Group Home	☐ On-campus Outpatient Hospital
☐ Acute Rehab	☐ Home	☐ Skilled Nursing Facility
☐ Ambulance – Air or Water	☐ Hospice	☐ Telehealth
☐ Ambulance – Land	☐ Independent clinic	☐ Urgent Care Facility
☐ Ambulatory Surgical Center	☐ Independent laboratory	Other - Please specify:
☐ Assisted Living Facility	☐ Inpatient hospital	
☐ Birthing Center	☐ Intermediate Care Facility	
☐ Custodial Care Facility	☐ Nursing Facility	
☐ End stage Renal Disease Tx	☐ Off-campus Outpatient Hospital	

Please enter below all codes requested; unlisted codes must have a description.
Include the quantity for each code requested and if applicable, left, right or bilateral designations.

ICD-10 Codes(s):
CPT/HCPC Code(s):

For questions: Call Blue Shield of California Promise Health Plan Provider Services at (800) 468-9935

This facsimile transmission may contain protected and privileged, highly confidential medical, Personal and Health Information (PHI) and/or legal information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate, or otherwise distribute it. If you are not the intended recipient, or if you have received this transmission in error, please notify the sender immediately and **confidentially** destroy the information that faxed in error. Thank you for your help in maintaining appropriate confidentiality.

Please include the documentation listed below when you return this form to Blue Shield of California Promise Health Plan:

- ☐ 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: (i.e., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management), when applicable
  - ☐ Results/reports of tests performed
  - ☐ Procedure report(s)