blue CALIFORNIA
PROMISE

Treatment Authorization Request	**Amniotic Membrane and Amniotic Fluid**
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.***

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

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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:
  - ☐ Reason/indication for human amniotic membrane/fluid product
  - ☐ Type, name, and amount of human amniotic membrane/fluid product
  - ☐ Wound measurements and wound care notes showing previous treatments
  - ☐ Procedure report including type and name of product used