

Treatment Authorization Request		Balloon Ostial Dilation for Treatment of Chronic and Recurrent Acute Rhinosinusitis	
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. <i>If there is no MD signature present, the request will be processed as a Standard request.</i>			
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 <i>If same as Referring/Prescribing Provider, Check Here</i> ☐			
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
☐	Acute Rehab	☐	Home
☐	Ambulance – Air or Water	☐	Hospice
☐	Ambulance – Land	☐	Independent clinic
☐	Ambulatory Surgical Center	☐	Independent laboratory
☐	Assisted Living Facility	☐	Inpatient hospital
☐	Birth Center	☐	Intermediate Care Facility
☐	Custodial Care Facility	☐	Nursing Facility
☐	End stage Renal Disease Tx	☐	Off-campus Outpatient Hospital
Other - Please specify:			
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:
 - Clinical indications/justification of procedure including duration of symptoms
 - Previous treatment(s), duration, and response(s) showing optimal medical therapy has been provided
 - Treatment plan
 - Pertinent radiological imaging results (i.e., CT and/or MRI and/or PET) including after optimal medical therapy
 - Procedure report(s)