



P R O M I S E

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|--|--------|----------------------------------|--------------------------|
| Treatment Authorization Request | | Transplant Authorization Request | |
| Phone Number Urgent and Standard: 1 (916) 841-1130 | | Fax Number: 1 (916) 350-8865 | |
| 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 has a 7-Calendar 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. | | | |
| Transplant Evaluation / Referral | | Transplant Procedure | Post-transplant services |
| New Standard Request | | New Urgent Request | |
| 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: | | | |
| <input type="checkbox"/> 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: | | ID Number: | |
| Address: | | | |
| Referring/Prescribing Provider: | | | |
| Name: | | Billing Tax ID: | NPI: |
| Street Address + Suite #: | | | |
| City: | State: | Zip: | Phone: |
| | | | Fax: |
| Type of Provider: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist Type: | | Contact Name and Phone Number: | |
| Servicing/Billing: Provider/Vendor/Lab <i>If same as Referring/Prescribing Provider Check Here</i> <input type="checkbox"/> | | | |
| Name: | | Billing Tax ID: | NPI: |
| Street Address + Suite #: | | | |

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|--|---|---|--------------------------------|------|
| City: | State: | Zip: | Phone: | Fax: |
| Specialist Type: | | | Contact Name and Phone Number: | |
| If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address: | | | | |
| Group Name: | | Billing Tax ID: | | NPI: |
| Street Address + Suite #: | | | | |
| City: | | State: | | Zip: |
| Billing Facility (If Applicable): | | | | |
| Facility Name: | | Billing Tax ID: | | NPI: |
| Street Address + Suite #: | | | | |
| City: | | State: | | Zip: |
| City: | | State: | | Zip: |
| City: | | State: | | Zip: |
| City: | | State: | | Zip: |
| Contact Name and Phone Number: | | | | |
| Anticipated Date of Service: | | | If Lab, Draw Date: | |
| Place of Service: (Check One Box Only or If typing replace box with an "X"): | | | | |
| <input type="checkbox"/> Office | <input type="checkbox"/> Home | <input type="checkbox"/> On Campus OP Hosp | | |
| <input type="checkbox"/> Acute Rehab | <input type="checkbox"/> Hospice | <input type="checkbox"/> PH | | |
| <input type="checkbox"/> Ambulance- Air or Water | <input type="checkbox"/> Independent Clinic | <input type="checkbox"/> RTC – Psychiatric | | |
| <input type="checkbox"/> Ambulance-Land | <input type="checkbox"/> Independent Laboratory | <input type="checkbox"/> RTC –SUD | | |
| <input type="checkbox"/> Ambulatory Surgical Center | <input type="checkbox"/> Inpatient Hospital | <input type="checkbox"/> Skilled Nursing Facility | | |
| <input type="checkbox"/> Assisted Living Facility | <input type="checkbox"/> Intermediate Care Facility | <input type="checkbox"/> Telehealth | | |
| <input type="checkbox"/> Birthing Center | <input type="checkbox"/> IOP | <input type="checkbox"/> Urgent Care Facility | | |
| <input type="checkbox"/> Custodial Care Facility | <input type="checkbox"/> IP Psychiatric Facility | <input type="checkbox"/> Other - Please Specify: | | |
| <input type="checkbox"/> End Stage Renal Disease Tx | <input type="checkbox"/> Nursing Facility | | | |
| <input type="checkbox"/> Group Home | <input type="checkbox"/> Off Campus OP Hosp | | | |
| Please enter all codes requested; unlisted codes must have a description. | | | | |
| Please include the quantity for each code requested and if applicable, left, right or bilateral designations. | | | | |
| ICD-10 Code(s): | | | | |
| CPT/HCPC Code(s): | | | | |
| For questions: Call BSC Medical Care Solutions Phone Number: 1-(916) 841-1130 | | | | |

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 provide the following documentation:

History and physical and/or consultation notes including:

Pertinent supporting documentation to facilitate your request, for example, the history & physical, test results, letter of medical necessity, etc.

Brief medical history (staging, underlying condition, previous remission, response to other therapies, co-morbidities).

Rationale for procedure.

DHCS COE Designation

Facility is a DHCS-approved transplant Center of Excellence (COE): Yes No

COE Name / NPI

Was the member evaluated and accepted by the transplant program?

Yes (attach documentation)

Pending evaluation

Date of COE evaluation / acceptance

For Out of State Facility Requests Only:

What is your facilities current contract standing for the requested transplant type?

What is your facilities reimbursement type?

Procedure Information:

Search and Evaluation only

HLA Typing

MUD Search

Stem Cell Collection and Storage

Transplant Type:

Autologous

Allogeneic Matched Unrelated

Donor Leukocyte infusion (DLI)

Cord Blood

Allogeneic Related

Kidney w/ Other Organ

Heart

Liver

Small Bowel

Pancreas

Lung

Other

Is this treatment part of a protocol? Yes No NCT# or N/A

If yes, please explain:

Date of Arrival for Pre-Transplant Treatment:

For Post-Transplant care, please provide date transplant occurred:

Visit our website at blueshieldca.com