

Treatment Authorization Request		Invasive Prenatal (Fetal) Diagnostic Testing	
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:		Billing 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:		Billing 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:	Billing Tax ID:	NPI:
Street Address + Suite#:		
City:	State:	Zip Code:
Billing Facility (If Applicable):		
Facility Name	Billing 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 for test
 - ☐ Type/name of test
 - ☐ Family history including known variant or carrier status of parents
 - ☐ Documentation of high risk pregnancy and why it is high risk
 - ☐ Evidence-based support for genetic test or specific gene(s) of interest
 - ☐ Other pertinent multidisciplinary notes/reports: genetic counseling
 - ☐ Prenatal ultrasound report, if applicable
 - ☐ Laboratory report(s)