blue CALIFORNIA

PROMISE

| **Treatment Authorization Request** | Rib Remodeling and Clavicle Shortening |
|---|---|
| **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: | **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: |
|---|---|---|

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association

| 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:
  - ☐ Clinical findings (i.e., pertinent symptoms and duration)
  - ☐ Comorbidities
  - ☐ Reason for procedure, when applicable
  - ☐ Pertinent past procedural and surgical history
  - ☐ Past and present diagnostic testing and results
  - ☐ Treatment plan (i.e., surgical intervention)
- ☐ Consultation and medical clearance report(s), when applicable
- ☐ Radiology report(s) and interpretation (i.e., MRI, CT, PET)
- ☐ 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)