Prior Authorization Request Form

Behavioral Health Services

Standard fax number: (844) 742-1155	**Urgent fax number: (844) 729-1416**

Use AuthAccel, Blue Shield of California's online authorization system, to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (**blueshieldca.com/provider**) and click the *Authorizations* tab to get started.

Blue Shield has a five business day turnaround 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.

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:

Type of request: ☐ New standard request ☐ Retro request ☐ Urgent request

If you are submitting a modification or extension, check one, and complete the details below:	☐ Modification request ☐ Extension request
Date last authorized:	Previous authorization number:

Provider justification for modification or extension:

Patient information

First name:	Last name:	
Date of birth (DOB):	Blue Shield subscriber ID number:	
Street address:	City:	
Home phone:	State:	ZIP code:
Cell phone:	Primary: ☐ Home ☐ Cell	

Servicing/Billing: Provider	**If same as requesting provider, check ☐**	
Provider first name:	Provider last name:	
Name:	Tax ID:	
NPI:	Specialist type:	
Street address and suite number:		
City:	State:	ZIP code:
Phone number:	Fax:	

If servicing provider is billing as part of a group contract enter the group name and address

Group name:	NPI:	
Street address and suite number:		
City:	State:	ZIP code:

Billing facility (if applicable)

Facility name:	NPI:	
Street address and suite number:		
City:	State:	ZIP code:
Phone number:	Fax:	
Contact name:	Contact phone number:	
Anticipated date of service/admission date:		

Types of services

Facility based services: ☐ Residential treatment center (RTC) ☐ Partial hospital program (PHP) ☐ Intensive outpatient program (IOP) Other outpatient services: ☐ Other: _____	Please utilize service specific Treatment Authorization Request forms for: Electroconvulsive therapy (ECT) Neuropsychological testing Transcranial magnetic stimulation (TMS) Applied behavior analysis (ABA)

Place of service

☐ Community mental health center ☐ Home ☐ Independent clinic ☐ Inpatient hospital ☐ Inpatient psychiatric facility ☐ Office	☐ Psychiatric facility partial hospitalization ☐ Psychiatric residential treatment center ☐ Residential substance abuse treatment facility ☐ Telehealth ☐ Other – Please specify _____

Service codes

Please enter all codes requested; unlisted codes must have a description. Please include quantity for each code requested.

ICD-10 code(s)		CPT/HCPCS code(s)	
Procedure code:	Quantity:	Procedure code:	Quantity:

Please provide the following documentation:

Clinical documentation including:

- Clinical findings (symptoms and duration)
- Treatment rationale
- Treatment history
- Family History
- Current living environment
- Goals
- Anticipated length of time in treatment
- Diagnostic testing and results
- Current medications (including dose, duration, response)
- Discharge plan

For questions: Call Blue Shield of California phone number at (800) 541-6652.