blue of california

Prior Authorization Request Form

(Please choose the appropriate policy for this request)

- ☐ Gender Affirmation Surgery
- ☐ Orthognathic Surgery
- ☐ Reconstructive Services

Standard Fax Number: 1 (844) 807-8997	**Urgent Fax Number:** 1 (844) 807-8996

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 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 ☐ 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:	ID Number:
Address:	

Referring/Prescribing Provider:

Name:			NPI:	
Street Address + Suite #:				
City:	State:	Zip:	Phone:	Fax:
Type of Provider: ☐ PCP ☐ Specialist Type:			Contact Name and Phone Number:	

Servicing/Billing: Provider/Vendor/Lab *If same as Referring/Prescribing Provider Check Here* ☐

Name:	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:		NPI:
Street Address + Suite #:		
City:	State:	Zip:

Billing Facility (If Applicable):

Facility Name:			NPI:	
Street Address + Suite #:				
City:	State:	Zip:	Phone:	Fax:
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"):

☐ Office	☐ Home	☐ On Campus OP Hosp
☐ Acute Rehab	☐ Hospice	☐ PHP
☐ Ambulance- Air or Water	☐ Independent Clinic	☐ RTC – Psychiatric
☐ Ambulance-Land	☐ Independent Laboratory	☐ RTC – SUD
☐ Ambulatory Surgical Center	☐ Inpatient Hospital	☐ Skilled Nursing Facility
☐ Assisted Living Facility	☐ Intermediate Care Facility	☐ Telehealth
☐ Birthing Center	☐ IOP	☐ Urgent Care Facility
☐ Custodial Care Facility	☐ IP Psychiatric Facility	☐ Other - Please Specify:
☐ End Stage Renal Disease Tx	☐ Nursing Facility	
☐ Group Home	☐ 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: 1-800-541-6652

Please provide the following documentation:

☐ Gender Affirmation Surgery

- ☐ History and physical and/or consultation notes including:
  - ☐ Clinical findings (i.e., pertinent symptoms and duration)
  - ☐ Comorbidities
  - ☐ Activity and functional limitations
  - ☐ Family history, if applicable
  - ☐ Reason for procedure/test/device, when applicable
  - ☐ Pertinent past procedural and surgical history
  - ☐ Past and present diagnostic testing and results
  - ☐ Prior conservative treatments, duration, and response
  - ☐ Treatment plan (i.e., surgical intervention)
- ☐ Consultation and medical clearance report(s), when applicable
- ☐ Radiology report(s) and interpretation (i.e., MRI, CT, discogram), when applicable
- ☐ Laboratory results
- ☐ Other pertinent multidisciplinary notes/reports: (i.e., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management), when applicable

Please provide the following documentation:

☐ Orthognathic Surgery

- ☐ History and physical and/or consultation notes including:
- ☐ Description and cause of the specific anatomic deformity present
- ☐ Diagnosis and evaluation
- ☐ Previous management of the functional medical impairment (if applicable)
- ☐ Symptoms related to the orthognathic deformity (if applicable)
- ☐ Diagnostic quality (clear) intra-oral and extra-oral photographs, two-view head photograph (front and side view)
- ☐ Bilateral cephalometric radiographs with measurements
- ☐ Cephalometric tracings and/or analysis
- ☐ Additional reports:
- ☐ Current study models with the appropriate bite registration or representation of patient's pre-surgical centric occlusion and /or centric relation bite
- ☐ Panorex x-ray or tomograms
- ☐ Documentation demonstrating completion of skeletal growth for cases under the age of 18 (except for Class II malocclusion-mandibular retrognathic)
- ☐ Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

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Please provide the following documentation:

☐ **Reconstructive Services**

- ☐ History and physical and/or consultation notes including:
  - ☐ Clinical indications for procedure/surgery
  - ☐ Documentation of any functional problems or limitations to be corrected by the procedure including the cause of the issue
  - ☐ Previous treatment(s) and response(s) (if applicable)
  - ☐ Proposed procedural treatment plan
- ☐ Office note(s) pertaining to the clinical problem and medical necessity of the procedure requested
- ☐ Quality color photographs which accurately depicts the extent of the clinical problem (as applicable)
  Any high-quality color images should be **securely** emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name and date of birth.

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