



Transplant Prior Authorization Form		Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer		
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 ( <a href="http://www.blueshieldca.com/provider">www.blueshieldca.com/provider</a> ) 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.				
<input type="checkbox"/> New Standard Request		<input type="checkbox"/> New Urgent Request		
<b>Important For Urgent Requests:</b> 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>				
<b>MD Signature REQUIRED For Urgent Requests Only:</b>				
<input type="checkbox"/> Modification Or <input type="checkbox"/> Extension Requests Complete the Section Below:				
Date Last Authorized:		Previous Authorization Number:		
MD/NP/PA justification for modification or extension:				
<b>Patient Information:</b>				
First Name:		Last Name:		
Date of Birth:		ID Number:		
Address:				
<b>Referring/Prescribing Provider:</b>				
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:	
<b>Servicing/Billing: Provider/Vendor/Lab</b> <i>If same as Referring/Prescribing Provider Check Here</i> <input type="checkbox"/>				
Name:		Billing Tax ID:	NPI:	
Street Address + Suite #:				

City:	State:	Zip:	Phone:	Fax:
Specialist Type:			Contact Name and Phone Number:	
<b>If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:</b>				
Group Name:		Billing Tax ID:		NPI:
Street Address + Suite #:				
City:		State:		Zip:
<b>Billing Facility (If Applicable):</b>				
Facility Name:		Billing Tax ID:		NPI:
Street Address + Suite #:				
City:		State:		Zip:
City:		State:		Zip:
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:	
<b>Place of Service: (Check One Box Only or If typing replace box with an "X"):</b>				
<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			
<b>Please enter all codes requested; unlisted codes must have a description.</b>				
<b>Please include the quantity for each code requested and if applicable, left, right or bilateral designations.</b>				
ICD-10 Code(s):				
CPT/HCPC Code(s):				
<b>For questions: Call BSC Medical Care Solutions Phone Number: 1-(916) 841-1130</b>				

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**Please provide the following documentation:**

**History and physical and/or consultation notes including:**

Bone marrow transplant consultation report and/or progress notes documenting:

- Diagnosis (including disease staging) and prognosis
- Synopsis of alternative treatments performed and results
- Specific transplant type being requested

Surgical consultation report and/or progress notes

Results of completed transplant evaluation including:

- Clinical history including comorbidities
- Specific issues identified during the transplant evaluation
- Consultation reports/letters (when applicable)
- Correspondence from referring providers (when applicable)
- Identification of donor for allogeneic related bone marrow/stem cell transplant (when information available)

Medical social service/social worker and/or psychiatric (if issues are noted)

evaluations including psychosocial assessment or impression of patient's ability to be an adequate candidate for transplant

Radiology reports including:

- Chest x-ray (CXR)
- PET scan, CT scan and bone survey (as appropriate)

Cardiology procedures and pulmonary function reports:

- EKG
- Uchocardiogram
- Pulmonary function tests (PFTs)

Biopsy/Pathology reports including:

- Bone marrow biopsy
- Lymph node biopsy (as appropriate)

Laboratory reports

Visit our website at [blueshieldca.com](http://blueshieldca.com)