

Prior Authorization Request Form		High Intensity Laser Therapy for Chronic Musculoskeletal Pain Conditions and Bell's Palsy		
Standard Fax Number: 1 (844) 807-8997		Urgent Fax Number: 1 (844) 807-8996		
<p>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.</p>				
<p>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.</p>				
<input type="checkbox"/> New Standard Request <input type="checkbox"/> New Urgent Request <input type="checkbox"/> Standing Referral				
<p>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></p>				
<p>MD Signature REQUIRED For Urgent Requests Only:</p>				
<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:				
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: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist Type:			Contact Name and Phone Number:	
Servicing/Billing: Provider/Vendor/Lab <i>If same as Referring/Prescribing Provider Check Here</i> <input type="checkbox"/>				
Name:		Tax ID:		NPI:
Street Address + Suite #:				

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:
City:		State:		Zip:
City:		State:		Zip:
City:		State:		Zip:
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"):				
<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			
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				
This facsimile transmission may contain protected and privileged, highly confidential medical, Personal and Health Information (PHI) and/or legal information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate, or otherwise distribute it. If you are not the intended recipient, or if you have received this transmission in error, please notify the sender immediately and confidentially destroy the information that faxed in error. Thank you for your help in maintaining appropriate confidentiality.				

Please provide the following documentation:

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)
- Laboratory results
- Other pertinent multidisciplinary notes/reports: (e.g., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management) when 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.

Visit our website at blueshieldca.com