



Prior Authorization Request Form		Home Health Care	
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.			
<input type="checkbox"/> New Standard Request		<input type="checkbox"/> New Urgent Request	<input type="checkbox"/> 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. <i>If there is no MD signature present the request will be processed as a Standard request.</i>			
MD Signature REQUIRED For Urgent Requests Only:			
<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:
Type of Provider: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist Type:		Fax:	
		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"/> Patients's Home Home Care Agency	
<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): S9123 (Nursing Care in the Home by RN – per hour) S9124 (Nursing Care in the Home by LPN/LVN – per hour)				
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.				

An Independent Member of the Blue Shield Association

Please provide the following documentation:

History and physical

Limitations that have rendered the member to be homebound

Notes indicating the current home health treatment plan to include what skilled services will be required

Frequency of requested visits: visit(s) per (day/week/month)

Length of each requested visit: hour(s) for each visit

Anticipated dates of service: / / - / / **OR** duration of request (days/months)

Total number of visits requested:

Total number of hours requested:

Is home health requested for medication administration? Y / N

If **yes**, name of the medication?

Does the medication require prior authorization? Y / N

If **yes**, please provide prior authorization number:

If **no**, Stop. (Submit Home Health request only after medication authorization number obtained.)

How many home health visits has this member had already in this calendar year?

***** Please call the Customer Service number on the back of the member's ID card for benefit, maximum, and eligibility verification.**

Visit our website at blueshieldca.com