Prior Authorization Request Form

(Please choose the appropriate policy for this request)* Cal PERS PPO/ASO Only

- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy

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 #:		

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	☐ PH
☐ 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:

Occupational Therapy

I hereby attest that the patient has successfully completed a total of 24 Occupational Therapy (OT) visits. This request is submitted for approval of the 25th and subsequent Occupational Therapy (OT) sessions.

Note: Prior authorization is not required for the initial 24 Occupational Therapy (OT) visits per member. However, for the 25th OT visit and any visits thereafter, submission of relevant medical records is necessary to support a review of medical necessity.

History and physical and/or consultation notes including:

- Clinical findings (i.e., pertinent symptoms and duration)
- Activity and physical and/or functional limitations
- 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., plan of care)

Other pertinent multidisciplinary notes/reports: (i.e., physical therapy, speech therapy) when applicable

Daily progress notes, including:

- Date of service
- Name of each modality and/or procedure performed
- Parameters for each modality (e.g., amperage/voltage, location of pads/electrodes)
- Area of treatment
- Total treatment time spent for each therapy (mandatory for times services)
- Total treatment time for each date of service
- Identity of the persons(s) providing the services

Note: At a minimum, documentation is required for every treatment day and for each therapy performed.

Please provide the following documentation:

Physical Therapy

I hereby attest that the patient has successfully completed a total of 24 Physical Therapy (PT) visits. This request is submitted for approval of the 25th and subsequent Physical Therapy (PT) sessions.

Note: Prior authorization is not required for the initial 24 Physical Therapy (PT) visits per member. However, for the 25th PT visit and any visits thereafter, submission of relevant medical records is necessary to support a review of medical necessity.

History and physical and/or consultation notes including:

- Initial physical therapy evaluation with documented goals
- Progress letters
- Daily treatment notes including flow sheets
- For additional treatments/extension of therapy, documentation of the need for the additional sessions as well as any new goals if applicable

Visit our website at blueshieldca.com

Please provide the following documentation:

Speech Therapy

I hereby attest that the patient has successfully completed a total of 24 Speech Therapy (ST) visits. This request submitted for approval of the 25th and subsequent Speech Therapy (ST) sessions.

Note: Prior authorization is not required for the initial 24 Speech Therapy (ST) visits per member. However, for the 25th ST visit and any visits thereafter, submission of relevant medical records is necessary to support a review of medical necessity.

History and physical and/or consultation notes including:

- Reason for speech therapy including documentation of the issue needing treatment
- Diagnoses related to the need for speech therapy
- Any applicable test results related to the need for speech therapy
- Provider prescription for speech therapy
- Standardized test score
- Treatment plan including:
  - Frequency and duration of treatment (e.g., 2 times per week for 6 months)
  - Functional, measurable, objective time-bound long- and short-term goals
  - Specific treatment techniques and/or activities to be used in treatment sessions

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