

Prior Authorization Request Form		Somatic Biomarker Testing (Including Liquid Biopsy) for Targeted Treatment in Non-Small-Cell Lung Cancer (EGFR, ALK, BRAF, ROSI, RET, MET, KRAS, NTRK)	
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. <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:			
☐ 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:
Type of Provider: ☐ PCP ☐ Specialist Type:			Fax:
Contact Name and Phone Number:			
Servicing/Billing: Provider/Vendor/Lab <i>If same as Referring/Prescribing Provider Check Here</i> ☐			
Name:		Tax ID:	
Street Address + Suite #:		NPI:	

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				
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:

- Diagnosis and cancer type and stage
- Previous treatment plan(s) and response(s)
- Current treatment plan
- Clinical justification for analysis testing
- Previous biopsies and any tissue limitations or contraindications to repeat biopsy

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