



P R O M I S E

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| Treatment Authorization Request | | Actigraphy | |
| Standard Fax Number: (323) 889-6506 | | Urgent Fax Number: (323) 889-5403 | |
| 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 Promise Health Plan 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"/> Retro 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: | | Blue Shield of California Promise ID Number: | |
| Street Address: | | | |
| City: | | State: | Zip Code: |
| Referring/Prescribing Provider: | | | |
| Name: | | BillingTax ID: | NPI: |
| Street Address + Suite#: | | | |
| City: | | State: | Zip Code: |
| Phone: | | Fax: | |
| Type of Provider: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist | | Specialist Type (if applicable): | |
| Contact Name and Phone Number: | | | |
| Servicing/Billing: Provider/Vendor/Lab <i>If same as Referring/Prescribing Provider, Check Here</i> <input type="checkbox"/> | | | |
| Name: | | BillingTax ID: | NPI: |

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| Street Address + Suite#: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | |
| Specialist Type: | | |
| Contact Name and Phone Number: | | |
| If Servicing Provider is billing as part of a Group Contract, enter the Group information below: | | |
| Group Name: | BillingTax ID: | NPI: |
| Street Address + Suite#: | | |
| City: | State: | Zip Code: |
| Billing Facility (If Applicable): | | |
| Facility Name | BillingTax ID: | NPI: |
| Street Address + Suite#: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | |
| Contact Name and Phone Number: | | |
| Anticipated Date of Service: | | If Lab, Draw Date: |
| Place of Service: (Check one box only): | | |
| <input type="checkbox"/> Office | <input type="checkbox"/> Group Home | <input type="checkbox"/> On-campus Outpatient Hospital |
| <input type="checkbox"/> Acute Rehab | <input type="checkbox"/> Home | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Ambulance – Air or Water | <input type="checkbox"/> Hospice | <input type="checkbox"/> Telehealth |
| <input type="checkbox"/> Ambulance – Land | <input type="checkbox"/> Independent clinic | <input type="checkbox"/> Urgent Care Facility |
| <input type="checkbox"/> Ambulatory Surgical Center | <input type="checkbox"/> Independent laboratory | <input type="checkbox"/> Other - Please specify: |
| <input type="checkbox"/> Assisted Living Facility | <input type="checkbox"/> Inpatient hospital | |
| <input type="checkbox"/> Birthing Center | <input type="checkbox"/> Intermediate Care Facility | |
| <input type="checkbox"/> Custodial Care Facility | <input type="checkbox"/> Nursing Facility | |
| <input type="checkbox"/> End stage Renal Disease Tx | <input type="checkbox"/> Off-campus Outpatient Hospital | |
| Please enter below all codes requested; unlisted codes must have a description. Include the quantity for each code requested and if applicable, left, right or bilateral designations. | | |
| ICD-10 Codes(s): | | |
| CPT/HCPC Code(s): | | |
| For questions: Call Blue Shield of California Promise Health Plan Provider Services at (800) 468-9935 | | |

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Please include the documentation listed below when you return this form to Blue Shield of California Promise Health Plan:

- 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: (i.e., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management), when applicable
 - Results/reports of tests performed
 - Procedure report(s)