



P R O M I S E

Treatment Authorization Request		Cryoablation of Tumors Located in the Kidney, Lung, Breast, Pancreas, or Bone	
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 If same as Referring/Prescribing Provider, Check Here <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., diagnosis of early-stage non-small cell lung cancer)
 - Tumor type size and location
 - Laboratory renal function reports specifically glomerular filtration rate (GFR) if applicable
 - Prior treatment and response
 - Reason for cryosurgical ablation versus standard surgical approach
 - Radiology report(s) and interpretation (i.e., MRI, CT, Chest x-ray)
 - Operative reports(s) or procedure report(s)