blue CALIFORNIA PROMISE

Treatment Authorization Request for Medi-Cal members

Insert name of policy (if applicable):	
Standard Fax Number: (323) 889-6506	**Urgent Fax Number: (323) 889-5403**

Use AuthAccel, Blue Shield of California'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.

Blue Shield has a 7 calendar days turn-around time on all Standard Prior Authorization Requests. Failure to complete this form in its may result in delayed processing or an adverse determination for insufficient information.

Type of Request: ☐ **New Standard Request** ☐ **New Urgent Request** ☐ **Retro Request** ☐ **Standing Referral**

Important information regarding 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 included, the request will be processed as a Standard Request.**

The following type of service should be faxed to the Urgent Fax number (above) to meet regulatory timeliness standards: Therapeutic Enteral Formula

An MD Signature is REQUIRED for Urgent Requests Only:	MD Signature:
If you are submitting a Modification or Extension, check one, and complete the details below:	☐ **Modification Request** ☐ **Extension Request**
Date last authorized:	Previous authorization number:
MD/NP/PA justification for modification or extension:	

Patient Information

First Name:	Last Name:		
Date of Birth (DOB):	Blue Shield Promise subscriber ID number:		
Street address:	City:	State:	ZIP code:

Referring/Prescribing provider or IPA

Name:		Tax ID:	National provider identifier (NPI):	
Street address and suite number:		City:	State:	ZIP code:
Phone number:	Fax number:	Type of provider: PCP ☐ Specialist ☐	Specialist type (if applicable):	
Contact name and phone number:				

If you have questions, please call Blue Shield Promise Provider Services at (800) 468-9935.

Servicing/Billing: Provider/Vendor Lab	**If same as referring/prescribing provider, check here:**		
First Name:	Last name:		
Street address and suite number:	City:	State:	ZIP code:
Phone number:	FAX:	Specialist type:	
Contact name and phone number:			
If the servicing provider is billing as part of a provider group contract, enter the group information below.			
Group name:	Tax ID:	NPI:	
Street address and suite number:	City:	State:	ZIP code:
Billing facility (if applicable)			
Faclity Name:	Tax ID:	NPI:	
Street address and suite number:	City:	State:	ZIP code:
Phone number:	FAX:	Specialist type:	
Contact name and phone number:			
Anticipated date of service:	If laboratory, enter draw date:		

Place of service: (Check one box only):

	Office		End stage renal disease		Nursing facility
	Acute Rehab		Group home		Off-campus outpatient hospital
	Ambulance – air or water		Home		On-campus out patient hospital
	Ambulance-land		Hospice		Skilled nursing facility
	Ambulatory surgical center		Independent clinic		Telehealth
	Assisted living facility		Independent laboratory		Urgent care facility
	Birthing center		Inpatient hospital	Other: Please specify:	
	Custodial care facility		Intermediate care facility		

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 code(s):

CPT/HCPC code(s):

If you have questions, please call Blue Shield Promise Provider Services at (800) 468-9935

Please include the documentation listed below when you return this form to Blue Shield Promise	
History and physical and/or consultation notes, including:	
• Clinical findings (i.e., pertinent symptoms and duration)	• Prior conservative treatments, duration, and response
• Comorbidities	• Treatment plan (i.e., surgical intervention)
• Activity and functional limitations	• Consultation and medical clearance report(s), when applicable
• Family history, if applicable	• Radiology report(s) and interpretation (i.e., MRI, CT, discogram)
• Reason for procedure/test/device, when applicable	• Laboratory results
• Pertinent past procedural and surgical history	• Other pertinent multidisciplinary notes
• Past and present diagnostic testing and results	• Community Health Worker Plan of Care

If you have questions, please call Blue Shield Promise Provider Services at (800) 468-9935