BlueCross BlueShield of Oklahoma

BlueLincs® HMO

Allergy Authorization Request
Fax: (918) 551-2211
www.bcbsok.com

Patient's Name _____ BlueLincs ID# _____

Date of Request _____ Date of Birth _____

Date of Service (if known) _____

Diagnosis _____ ICD 9 _____

PCP Name _____ Specialist Name _____

PCP Phone _____ Specialist Phone _____

PCP Fax _____ Specialist Fax _____

PCP Contact Person _____ Specialist Contact Person _____

Number of visits needed: _____ CPT Code _____

Allergy testing needed: ☐ Yes ☐ No CPT Code _____

Monthly Medication

- ○ Doses — Number per month ____ CPT Code _____
- ○ Treatments
- ○ Units
- ○ Injections

Number of vials of serum needed per month _____ CPT Code _____
You must bill monthly. BlueLincs will only pay for one month of serum at a time.

Number of injections per vial ____

Frequency of injections ____

Will be administered by: ☐ Specialist ☐ PCP ☐ Other

Additional CPT Code needed (such as pulmonary function testing) _____

Comments: _____

Authorization number given by BlueLincs:

Office visits and testing _____

Serum and injections _____

Authorization valid from _____ until _____

Most benefit plans have a 50 percent copay for allergy serum and the administration of allergy serum. This referral does not guarantee payment for services provided. Payment depends upon member eligibility, benefits and participation in BlueLincs program.

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