

☐ Satisfy the above description as urgent in nature

MEMBER ID NUMBER (INCLUDE 3-CHARACTER PREFIX)

PHYSICIAN/FACILITY/PROVIDER INFORMATION

CASE INFORMATION

CASE NUMBER (IF APPLICABLE)

CPT/HCPCS CODE

## **Expedited Pre-service Clinical Appeal Request Form**

☐ Determined by Blue Cross and Blue Shield of Oklahoma

(Commercial Networks Only)

An expedited pre-service clinical appeal may be requested if the member, an authorized representative or the physician feels that non-approval of the requested service may seriously jeopardize the member's health. An appeal also may be submitted if, in the opinion of the practitioner with knowledge of the member's medical condition, non-approval would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

This process does not apply to non-urgent, post-service or retrospective requests.

The medical service or treatment should meet the following criteria:

☐ Has not yet taken place or is ongoing ☐ Not covered for clinical reasons or not in b	penefit	(BCBSOK) to be med investigational or m	dically unnecessary, experimental, edically unproven
Instructions			
Once it has been determined that the BCBSC met, please proceed as follows:	DK criteria for sub	omitting an expedited c	linical pre-service appeal have been
<ol> <li>Fill out the form below, using the tab key to</li> <li>Print out your completed form and use it as</li> <li>Include medical records, office notes, fax co</li> <li>Fax this request form and any new support Department. For FEP expedited appeals, fax</li> </ol>	s your cover shee over sheet and ar ing documentatio	t ny other necessary docu	11 3
PATIENT INFORMATION		TODAY'S DATE	
PATIENT FIRST NAME	PATIENT LAST NAME		PATIENT'S DATE OF BIRTH (MM/DD/YYYY)
MEMBER FIRST NAME		MEMBER LAST NAME	
MEMBER ID NUMBER (INCLUDE 3-CHARACTER PREFIX)		GROUP NUMBER	

PHYSICIAN NAME (ATTENDING PROVIDER FULL NAME) NPI PHONE NUMBER FAX NUMBER FACILITY OR PROVIDER/GROUP NAME APPELLANT INFORMATION NAME OF INDIVIDUAL SUBMITTING APPEAL PHONE NUMBER **FAX NUMBER** 

PLACE OF SERVICE (FACILITY NAME)

PROCEDURE(S) NON-ALLOWED