



## Blue Cross Medicare Advantage<sup>SM</sup> Prior Authorization Form

*Type of Prior Authorization:  Outpatient  Inpatient*

**Expedited means that waiting up to 14 days places the member's life, health, or ability to regain function in serious danger. CMS Expedited Status:  Yes  No**

### Member Information

**Member ID #**

### Request Information

**Type of Request:  Initial  Extension  Pre-service  Concurrent  Post-service**

Start date

End date

Requested units (i.e. how many visits?)

Diagnosis code/ICD -10 (Required)

Procedure code /CPT-HCPCS  
(Required unless it is only inpatient not related to surgery)

Type of service (i.e., Radiology, Diagnostic, DME)

### Provider Information

Contact Name

Contact Phone Number

**Facility Name (If not being performed in the offi**

NPI/Network Status

Address and Phone Number

**Submitting Physician Name**

NPI/Network Status

Address and Phone Number

**Servicing Physician Name**

NPI/Network Status

Address and Phone Number

\*\*\*Please attach supporting documentation to facilitate the request (i.e., history & physical, letter of medical necessity, original photographs, etc.). Please place this form on top of the information being submitted.

**Please write clearly or complete on-screen, then print and fax to 1-855-874-4711, or mail the Prior Authorization form to P.O. Box 4288, Scranton PA 18505.**

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