



Blue Cross Medicare AdvantageSM 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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