blue california | Promise Health Plan

Blue Shield of California Promise Health Plan
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SNF SERVICE AUTHORIZATION REQUEST

❒ ROUTINE ❒RETROACTIVE ❒URGENT

I. PATIENT INFORMATION

PRIMARY LANGUAGE SPOKEN: _____

Require Interpreter: ❒Yes ❒No ❒American Sign Language

Member Name: _____ DOB: _____ Gender: ❒ F ❒ M

Member Address: _____ City: _____ Zip: _____ Phone: _____

Member ID#: _____ ❒ Medicare ❒ Medi-Cal ❒ Cal MediConnect

II. REFER TO INFORMATION

Date of Request: _____ Provider Name: _____ Specialty: _____

Provider Address: _____ Phone: _____ Fax: _____

Facility Name: _____ Phone: _____ Fax: _____

III. AUTISM

❒ Autism Diagnostic Evaluation

IV. SERVICE(S) REQUESTED (Use ICD-10 Codes for Date of Service Request on or after 10/01/2015)

❒ Initial Consult ❒ FU Visit(s) _____ ❒ Health Education (Specify): _____

❒ Inpatient Admission ❒ Outpatient procedure(s) ❒ Other: _____

Diagnosis: _____ ICD-10 Code(s): _____

Service(s)/Procedure(s): _____ CPT 4 Code(s): _____

Reason for Request: _____

Relevant labs/X-Rays, etc.: _____

Prior Treatment & Results: _____

Requesting Physicians Name: _____ Phone #: _____

Physician's Signature: _____ Fax #: _____

Accident: ❒YES ❒NO Where Occurred: ❒ Home ❒ Work ❒ Auto ❒ Other

STATUS: ❒ APPROVED ❒ MODIFIED ❒DEFERRED ❒DENIAL

Auth #: _____ Date Approved: _____ Date Auth. Expire: _____

Comments: _____

Reviewer's Name: _____ Signature: _____ Date: _____

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN USE ONLY: Member Eligibility as of: _____

❒ IPA RESPONSIBILITY Date faxed to IPA: _____ PCP Provider ID#: _____

THIS REFERRAL DOES NOT GUARANTEE ELIGIBILITY. CHECK ELIGIBILITY PRIOR TO RENDERING SERVICE. Payment will NOT be made for unauthorized services. All lab and x-rays must be ordered/performed by contracting providers. Contact Blue Shield of California Promise Health Plan U.M. Department at above number, if unsure. Specialist reports must be sent to PCP promptly.

Revised Date: 04/15/2019