blue california
Promise Health Plan

Treatment Authorization Request for Medi-Cal members

Insert name of policy (if applicable):	
Standard Fax Number: (323) 889-6506	**Urgent Fax Number: (323) 889-5403**

Use AuthAccel, Blue Shield of California's online authorization system, to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

Blue Shield has a 5 business day turn-around time on all Standard Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Type of Request: ☐ **New Standard Request** ☐ **New Urgent Request** ☐ **Retro Request** ☐ **Standing Referral**

Important information regarding urgent requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. **If there is no MD signature included, the request will be processed as a Standard Request.**

The following type of service should be faxed to the Urgent Fax number (above) to meet regulatory timeliness standards: Therapeutic Enteral Formula

An MD Signature is REQUIRED for Urgent Requests Only:	MD Signature:
If you are submitting a Modification or Extension, check one, and complete the details below:	☐ **Modification Request** ☐ **Extension Request**
Date last authorized:	Previous authorization number:
MD/NP/PA justification for modification or extension:	

Patient Information

First Name:	Last Name:		
Date of Birth (DOB):	Blue Shield Promise subscriber ID number:		
Street address:	City:	State:	ZIP code:

Referring/Prescribing provider or IPA

Name:		Tax ID:	National provider identifier (NPI):	
Street address and suite number:		City:	State:	ZIP code:
Phone number:	Fax number:	Type of provider: PCP ☐ Specialist ☐	Specialist type (if applicable):	
Contact name and phone number:				

If you have questions, please call Blue Shield Promise Provider Services at (800) 468-9935.

Servicing/Billing: Provider/Vendor Lab	**If same as referring/prescribing provider, check here:**		
First Name:	Last name:		
Street address and suite number:	City:	State:	ZIP code:
Phone number:	FAX:	Specialist type:	
Contact name and phone number:			
If the servicing provider is billing as part of a provider group contract, enter the group information below.			
Group name:	Tax ID:	NPI:	
Street address and suite number:	City:	State:	ZIP code:
Billing facility (if applicable)			
Faclity Name:	Tax ID:	NPI:	
Street address and suite number:	City:	State:	ZIP code:
Phone number:	FAX:	Specialist type:	
Contact name and phone number:			
Anticipated date of service:	If laboratory, enter draw date:		

Place of service: (Check one box only):

	Office		End stage renal disease		Nursing facility
	Acute Rehab		Group home		Off-campus outpatient hospital
	Ambulance – air or water		Home		On-campus out patient hospital
	Ambulance-land		Hospice		Skilled nursing facility
	Ambulatory surgical center		Independent clinic		Telehealth
	Assisted living facility		Independent laboratory		Urgent care facility
	Birthing center		Inpatient hospital	Other: Please specify:	
	Custodial care facility		Intermediate care facility		

Please enter below all codes requested. Unlisted codes must have a description. Include the quantity for each code requested and if applicable, left, right or bilateral designations.

ICD-10 code(s):

CPT/HCPC code(s):

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Please include the documentation listed below when you return this form to Blue Shield Promise	
History and physical and/or consultation notes, including:	
• Clinical findings (i.e., pertinent symptoms and duration)	• Prior conservative treatments, duration, and response
• Comorbidities	• Treatment plan (i.e., surgical intervention)
• Activity and functional limitations	• Consultation and medical clearance report(s), when applicable
• Family history, if applicable	• Radiology report(s) and interpretation (i.e., MRI, CT, discogram)
• Reason for procedure/test/device, when applicable	• Laboratory results
• Pertinent past procedural and surgical history	• Other pertinent multidisciplinary notes
• Past and present diagnostic testing and results	• Community Health Worker Plan of Care

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