



P R O M I S E

<b>Treatment Authorization Request</b>		<b>Genetic Biomarker Testing (Including Liquid Biopsy) for Targeted Treatment in Advanced Cancer</b>	
<b>Standard Fax Number:</b> (323) 889-6506		<b>Urgent Fax Number:</b> (323) 889-5403	
<p><b>Use AuthAccel - Blue Shield's online authorization system</b> - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (<a href="http://www.blueshieldca.com/provider">www.blueshieldca.com/provider</a>) and click the Authorizations tab to get started.</p>			
<p><b>Notice: Blue Shield of CA 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.</b></p>			
<p><input type="checkbox"/> <b>New Standard Request</b>    <input type="checkbox"/> <b>New Urgent Request</b>    <input type="checkbox"/> <b>Retro Request</b>    <input type="checkbox"/> <b>Standing Referral</b></p>			
<p><b>Important For Urgent Requests:</b> 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. <i>If there is no MD signature present, the request will be processed as a Standard request.</i></p>			
<p><b>MD Signature REQUIRED For Urgent Requests Only:</b></p>			
<p><input type="checkbox"/> <b>Modification Or</b>    <input type="checkbox"/> <b>Extension Requests Complete the Section Below:</b></p>			
Date Last Authorized:		Previous Authorization Number:	
MD/NP/PA justification for modification or extension:			
<b>Patient Information:</b>			
First Name:		Last Name:	
Date of Birth:		Blue Shield of California Promise ID Number:	
Street Address:			
City:		State:	Zip Code:
<b>Referring/Prescribing Provider:</b>			
Name:		Tax ID:	NPI:
Street Address + Suite#:			
City:		State:	Zip Code:
Phone:		Fax:	
Type of Provider: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist		Specialist Type (if applicable):	
Contact Name and Phone Number:			
<b>Servicing/Billing: Provider/Vendor/Lab</b> <i>If same as Referring/Prescribing Provider, Check Here</i> <input type="checkbox"/>			
Name:		Tax ID:	NPI:

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Street Address + Suite#:		
City:	State:	Zip Code:
Phone:	Fax:	
Specialist Type:		
Contact Name and Phone Number:		
<b>If Servicing Provider is billing as part of a Group Contract, enter the Group information below:</b>		
Group Name:	Tax ID:	NPI:
Street Address + Suite#:		
City:	State:	Zip Code:
<b>Billing Facility (If Applicable):</b>		
Facility Name	Tax ID:	NPI:
Street Address + Suite#:		
City:	State:	Zip Code:
Phone:	Fax:	
Contact Name and Phone Number:		
<b>Anticipated Date of Service:</b>		<b>If Lab, Draw Date:</b>
<b>Place of Service: (Check one box only):</b>		
<input type="checkbox"/> Office	<input type="checkbox"/> Group Home	<input type="checkbox"/> On-campus Outpatient Hospital
<input type="checkbox"/> Acute Rehab	<input type="checkbox"/> Home	<input type="checkbox"/> Skilled Nursing Facility
<input type="checkbox"/> Ambulance – Air or Water	<input type="checkbox"/> Hospice	<input type="checkbox"/> Telehealth
<input type="checkbox"/> Ambulance – Land	<input type="checkbox"/> Independent clinic	<input type="checkbox"/> Urgent Care Facility
<input type="checkbox"/> Ambulatory Surgical Center	<input type="checkbox"/> Independent laboratory	<input type="checkbox"/> Other - Please specify:
<input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Inpatient hospital	
<input type="checkbox"/> Birthing Center	<input type="checkbox"/> Intermediate Care Facility	
<input type="checkbox"/> Custodial Care Facility	<input type="checkbox"/> Nursing Facility	
<input type="checkbox"/> End stage Renal Disease Tx	<input type="checkbox"/> Off-campus Outpatient Hospital	
<b>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.</b>		
ICD-10 Codes(s):		
CPT/HCPC Code(s):		
<b>For questions: Call Blue Shield Promise Provider Services at (800) 468-9935</b>		

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**Please include the documentation listed below when you return this form to Blue Shield of California Promise Health Plan:**

- History and physical and/or consultation notes, including:
  - Clinical findings (i.e., pertinent symptoms and duration)
  - Current diagnoses and status (i.e., type of cancer, stage)
  - Date of diagnosis
  - Family history, if applicable
  - Reason for test when applicable
  - Treatment plan
- Pertinent past procedural and surgical history (i.e., biopsies, resections, etc.)
- Pathology report(s)
- Pertinent past genetic tests (i.e., somatic/tumor or germline test results including but not limited to HER2, PD-L1, MSI, BRCA, etc.)
- Results/reports of tests performed
- Procedure report(s)