



P R O M I S E

Treatment Authorization Request		Germline Genetic Testing for Hereditary Breast/Ovarian Cancer Syndrome and Other High-Risk Cancers (BRCA1, BRCA2, PALB2)	
Standard Fax Number: (323) 889-6506		Urgent Fax Number: (323) 889-5403	
Use AuthAccel - Blue Shield'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.			
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.			
<input type="checkbox"/> New Standard Request <input type="checkbox"/> New Urgent Request <input type="checkbox"/> Retro Request <input type="checkbox"/> Standing Referral			
Important For 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. <i>If there is no MD signature present, the request will be processed as a Standard request.</i>			
MD Signature REQUIRED For Urgent Requests Only:			
<input type="checkbox"/> Modification Or <input type="checkbox"/> Extension Requests Complete the Section Below:			
Date Last Authorized:		Previous Authorization Number:	
MD/NP/PA justification for modification or extension:			
Patient Information:			
First Name:		Last Name:	
Date of Birth:		Blue Shield of California Promise ID Number:	
Street Address:			
City:		State:	Zip Code:
Referring/Prescribing Provider:			
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:			
Servicing/Billing: Provider/Vendor/Lab <i>If same as Referring/Prescribing Provider, Check Here</i> <input type="checkbox"/>			

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association

Name:		Tax ID:		NPI:	
Street Address + Suite#:					
City:		State:		Zip Code:	
Phone:			Fax:		
Specialist Type:					
Contact Name and Phone Number:					
If Servicing Provider is billing as part of a Group Contract, enter the Group information below:					
Group Name:		Tax ID:		NPI:	
Street Address + Suite#:					
City:		State:		Zip Code:	
Billing Facility (If Applicable):					
Facility Name		Tax ID:		NPI:	
Street Address + Suite#:					
City:		State:		Zip Code:	
Phone:			Fax:		
Contact Name and Phone Number:					
Anticipated Date of Service:			If Lab, Draw Date:		
Place of Service: (Check one box only):					
<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	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		
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 Codes(s):					
CPT/HCPC Code(s):					

For questions: Call Blue Shield Promise Provider Services at (800) 468-9935

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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:
 - Ethnicity/Ancestry
 - Personal and/or family history of cancer (if applicable) including:
 - Family relationship(s): (maternal or paternal), (family member [e.g., sibling, aunt, grandparent]), (living or deceased) (if applicable)
 - Site(s) and stage of cancer (if applicable)
 - Age at diagnosis (including family members) (if applicable)
 - If breast cancer, indicate if bilateral, premenopausal, or triple negative cancer
 - BRCA1/BRCA2* or *PALB2* mutation history (if applicable)
- Genetic counseling/professional results (if applicable)
- Laboratory or Pathology reports (if applicable)
- Applicable known family genetic variants and the relationship to the individual being tested
- Procedure report(s)
- Applicable test results