

Treatment Authorization Request		Multimarker Serum Testing Related to Ovarian Cancer	
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.			
☐ New Standard Request ☐ New Urgent Request ☐ Retro Request ☐ 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:			
☐ Modification Or ☐ 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: ☐ PCP ☐ 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> ☐			
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):			
☐ Office	☐ Group Home	☐ On-campus Outpatient Hospital	
☐ Acute Rehab	☐ Home	☐ Skilled Nursing Facility	
☐ Ambulance – Air or Water	☐ Hospice	☐ Telehealth	
☐ Ambulance – Land	☐ Independent clinic	☐ Urgent Care Facility	
☐ Ambulatory Surgical Center	☐ Independent laboratory	☐ Other - Please specify:	
☐ Assisted Living Facility	☐ Inpatient hospital		
☐ Birthing Center	☐ Intermediate Care Facility		
☐ Custodial Care Facility	☐ Nursing Facility		
☐ End stage Renal Disease Tx	☐ 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			

This facsimile transmission may contain protected and privileged, highly confidential medical, Personal and Health Information (PHI) and/or legal information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate, or otherwise distribute it. If you are not the intended recipient, or if you have received this transmission in error, please notify the sender immediately and **confidentially** destroy the information that faxed in error. Thank you for your help in maintaining appropriate confidentiality.

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)
 - ☐ Comorbidities
 - ☐ Activity and functional limitations
 - ☐ Family history, if applicable
 - ☐ Reason for procedure/test/device, when applicable
 - ☐ Pertinent past procedural and surgical history
 - ☐ Pertinent past and present diagnostic testing and results
 - ☐ Prior pertinent treatments, duration, and response
 - ☐ Treatment plan (i.e., surgical or medication intervention)
- ☐ Consultation and medical clearance report(s), when applicable
- ☐ Radiology report(s) and interpretation (i.e., MRI, CT, US)
- ☐ Results/reports of tests performed
- ☐ Procedure report(s)