

Treatment Authorization Request		Tumor-Informed Circulating Tumor DNA Testing for Cancer Management	
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					
☐	Birth 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								

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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)
 - ☐ Activity and functional limitations
 - ☐ Family history, if applicable
 - ☐ Reason for procedure/test/device, when applicable (e.g., routine screening, suspected recurrence or progression, etc.)
 - ☐ Pertinent past procedural and surgical history
 - ☐ Past and present diagnostic testing and results, including previous MRD testing
 - ☐ Prior treatments, duration, and response
 - ☐ Treatment plan (i.e., surgical intervention)
- ☐ Radiology report(s) and interpretation (i.e., MRI, CT, PET)
- ☐ Results/reports of tests performed
- ☐ Procedure report(s)