

Request for Preauthorization of Benefits for Ancillary Service

Please refer to our website, BlueChoiceSC.com, for a complete list of ancillary services that require authorization.

Fax this form to BlueChoice HealthPlan, Health Care Services

Fax: 800-610-5685 or 803-714-6463

Original (Prospective) Request

Reauthorization (Concurrent) Request

MEMBER INFORMATION

Member's Name: _____

Member's ID #: _____ DOB: _____

Home Phone: _____ Alternate Phone: _____

Primary Diagnosis: _____ ICD9: _____

Secondary Diagnosis: _____ ICD9: _____

Height: _____ Weight: _____ (Provide if necessary to service member — selecting size, dose, etc.)

YOUR INFORMATION

Provider's Name: _____ Location: _____

Tax ID Number: _____ NPI: _____

Contact's Name: _____ Phone: _____ Fax: _____

PHYSICIAN INFORMATION

Physician's Name: _____ NPI: _____

Phone: _____ Fax: _____ UPIN: _____

(Continued on back.)

The attached information is confidential and is intended only for the use of the addressee identified above. If the reader of this message is not the intended recipient(s), please be advised that any dissemination, distribution or copying of the communication is strictly prohibited. Anyone who receives this communication in error should notify us immediately by telephone (1-800-327-3183). The document can be faxed to us at (1-800-610-5685). After contacting us, the original document can be destroyed or returned to us via U.S. mail by sending to the following address: BlueChoice HealthPlan, Mail Code AX-325, P.O. Box 5170, Columbia, SC 29260-6170.

Member's Name: _____

ID #: _____

TYPE OF SERVICE REQUESTED

DME Home Health Prosthetics

SERVICES REQUESTED

Billing Code (HCPCS, CPT)	Description	Quantity (Days or Units)	Pricing	Dates of Service (From – To)

Rental Purchase

Please attach pertinent clinical documentation and indicate the number of pages you are faxing to us, including cover page. Thanks! _____ Pages

NOTE: 1) Miscellaneous, NOS, custom and non-contracted codes/services must be accompanied by an invoice showing U&C charge and description of services/products to be rendered to member. 2) All drug requests must include a complete physician's prescription. 3) All special medical devices requests must include clinical records and information explaining medical necessity. 4) Re-authorization request for home health services must include Plan of Care and most recent nursing and/or therapy notes.

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