BlueChoice® HealthPlan
South Carolina
An independent licensee of the Blue Cross and Blue Shield Association

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.)

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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.