Preauthorization inpatient elective admission

Capital

Fax completed form to: **717.651.8966**

Section I: Member information		
Member name:	Member ID:	Date of birth:
Product: ☐ CHIP ☐ Commercial ☐ FEP ☐ Medicare Advantage		
Does member have other primary insurance? ☐ N/A ☐ Workers' comp ☐ Auto ☐ Other:		

Section II: Authorization

Level of urgency:

☐ **Standard** request (routine care)—Care/treatment that is not emergent, urgent, or preventive in nature.

☐ **Expedited** request—Care/treatment that is emergent or the application of the timeframe for making standard/routine or not life-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For expedited request, please explain:

Section III: Clinical summary		
Place of service: ☐ Hospital ☐ Other:		
Admission date:	End date:	Requested units/days:
Primary diagnosis:	Additional diagnosis:	
Primary procedure/HCPC codes:		
All pertinent clinical information must be included.		

Section IV: Servicing provider information	
Name:	Provider NPI:
If service/procedure is being done in a facility, name of facility:	Facility NPI (if known):
Local Blue Plan (if yes, please provide local Blue Plan identification):	
Address:	
City: State: ZIP Code:	
Contact name: Contact phone: Fax:	

Section V: Requesting provider information (if different than above)		
Name:	Provider NPI:	
Address:		
City:	State:	ZIP Code:
Contact name:	Contact phone:	Fax:

Section VI: Additional information

To prevent delay of this review, please include all pertinent clinical information such as:

☐ Most recent H&P. ☐ Progress notes. ☐ Diagnostic studies. ☐ Photo(s). ☐ Molds.

Any questions, contact Capital Blue Cross Preauthorization department at **800.471.2242**	Capital Blue Cross letter of medical necessity mailing address UM department Capital Blue Cross PO Box 773731 Harrisburg, PA 17177-3731

Section VII: Physician signature

Please sign: Date:

(Preauthorization is not a guarantee of payment.)