Preauthorization letter of medical necessity

Capital

Fax completed form to: **717.540.2171**
To ensure accurate and timely processing of your request, please complete all fields on the form.

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

Authorization type: ☐ Initial authorization ☐ Reauthorization (subsequent) Prior authorization number:

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: ☐ Inpatient ☐ Outpatient ☐ MD office ☐ Other:

Date of service: Requested end date: Requested units/days:

Primary diagnosis: Additional diagnosis:

All procedure/HCPC code(s):

**All pertinent clinical information must be submitted with this request **

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:

Section V: Requesting provider information (if different than above)

Provider name: Provider NPI:

Address:

City: State: ZIP Code:

Contact name:	Contact phone: Fax:

Section VI: Additional information (required)

To prevent any delay with the review process, please include all pertinent clinical information such as:

☐ Initial evaluation ☐ Progress notes ☐ Molds ☐ Photos

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 VI: Physician signature

Please sign: Date:

(Preauthorization is not a guarantee of payment.)