Blue Cross complete of Michigan

Prior Authorization Request Form

Please type this document to ensure accuracy and to expedite processing.
All fields must be completed for the request to be processed.
Please make a selection where applicable throughout the document.

DATE	
TYPE OF REQUEST	_____ URGENT _____ STANDARD _____ RETROSPECTIVE
TREATMENT SETTING	_____ INPATIENT _____ OUTPATIENT
REQUEST TYPE	_____ EXTENSION _____ INITIAL _____ CANCEL _____ CHANGES DOS/SETTING
	_____ ADDITIONAL CLINICAL _____ DISCHARGE PLANNING _____ OTHER
PREVIOUS AUTHORIZATION NUMBER	
CONTACT NAME	
CONTACT PHONE	CONTACT FAX

MEMBER INFORMATION

LAST NAME		
FIRST NAME		
MEMBER ID (MEDICAID ID OR HEALTH PLAN ID)		
MEMBER PHONE NUMBER	DATE OF BIRTH	
MEMBER STREET ADDRESS		
CITY	STATE	ZIP

PROVIDER INFORMATION

PROVIDER NAME			
PROVIDER TIN	PROVIDER NPI		
PROVIDER PHONE NUMBER	PROVIDER FAX NUMBER		
PROVIDER STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			
FACILITY NAME			
FACILITY TIN	FACILITY NPI		
FACILITY PHONE NUMBER	FACILITY FAX NUMBER		
FACILITY STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			

REFERRING PHYSICIAN NAME (IF DIFFERENT FROM ABOVE)
REFERRING PHYSICIAN TIN
REFERRING PHYSICIAN NPI
REFERRING PHYSICIAN PHONE NUMBER
REFERRING PHYSICIAN FAX NUMBER
REFERRING PHYSICIAN STREET ADDRESS
CITY STATE ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING

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MEDICAL SECTION

DIAGNOSIS CODE		

PROCEDURE CODE	START DATE	END DATE	NUMBER OF UNITS	CODE DESCRIPTION

Blue Cross complete of Michigan

MEDICAL SECTION

NOTES

PLEASE FAX TO **1-888-989-0019**

IN ORDER TO PROCESS YOUR REQUEST IN A TIMELY MANNER, PLEASE SUBMIT ANY PERTINENT CLINICAL INFORMATION TO SUPPORT THE REQUEST FOR SERVICES. IF AN OUT-OF-NETWORK PROVIDER IS BEING USED, PLEASE SUBMIT DOCUMENTATION TO SUBSTANTIATE THE USE OF AN OUT-OF-NETWORK PROVIDER AS WELL. PLEASE CONTACT OUR UTILIZATION MANAGEMENT DEPARTMENT AT **1-888-312-5713** WITH QUESTIONS.

URGENT MEDICAL CONDITION: ANY ILLNESS, INJURY, OR SEVERE CONDITION WHICH, UNDER REASONABLE STANDARDS OF MEDICAL PRACTICE, WOULD BE DIAGNOSED AND TREATED WITHIN A 24-HOUR PERIOD AND, IF LEFT UNTREATED, COULD RAPIDLY BECOME A CRISIS OR EMERGENCY MEDICAL CONDITION. THE TERM ALSO INCLUDES SITUATIONS WHERE A PERSON'S DISCHARGE FROM A HOSPITAL WILL BE DELAYED UNTIL SERVICES ARE APPROVED OR A PERSON'S ABILITY TO AVOID HOSPITALIZATION DEPENDS UPON PROMPT APPROVAL OF SERVICES.

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