

**Blue Cross and Blue Shield of Minnesota
and Blue Plus**



Prior Authorization/Precertification Request

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) prior authorization: 866-518-8448; Fax: 1-800-964-3627
To prevent delay in processing your request, please fill out this form in its entirety with all applicable information.

Is this admission/procedure/service/item required urgently? YES / NO By definition urgently needed services mean that if the standard timeframe was applied it may seriously jeopardize the member's health or ability to regain maximum functioning or subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Today's date: _____ **Provider return fax:** _____

Member information

First name: _____ Last name: _____
 Address: _____ City, State ZIP code: _____
 Member ID: _____ Contact phone: _____ DOB: _____
 Additional member information: _____

Referring provider **Participating** **Nonparticipating**

Full name: _____
 NPI: _____ Provider ID: _____ TIN: _____
 Office contact name: _____ Office phone: _____ Office fax: _____
 Address: _____ City, State ZIP code: _____
 Specialty: _____

Servicing provider **Participating** **Nonparticipating**

Full name: _____
 NPI: _____ Provider ID: _____ TIN: _____
 Office contact name: _____ Office phone: _____ Office fax: _____
 Address: _____ City, State ZIP code: _____
 Specialty: _____

Servicing facility **Participating** **Nonparticipating**

Name: _____
 NPI: _____ Provider ID: _____ TIN: _____
 Facility contact name: _____ Facility phone: _____ Facility fax: _____
 Address: _____ City, State ZIP code: _____

Requested service (For type of service, check all that apply.) **Date/date range of service:** _____

ICD-10 code(s): _____
CPT code(s) (include requested units): _____

Type of service: Outpatient Inpatient Skilled nursing facility
 Long-term services & supports/long-term care Home health
 Durable medical equipment Diagnostic study Hospice
 Office visit Personal care services Other:
Place of service: Hospital Ambulatory surgery center Office
 Home Independent lab Nursing facility Other:
 Additional information: _____

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization from Blue Cross, please provide the authorization number with your submission.

This area is reserved for the definition of what is considered expedited, urgent or emergent.
 Emergent — Use for **all** nonelective **inpatient** admissions only when provider indicates that the admission was urgent, emergent or expedited (for admission on same day).
 Urgent — Use for **outpatient** services only when provider indicates that the service is urgent, emergent or expedited.

Disclaimer: Authorization is based on verification of member eligibility and benefit coverage at the time of service and is subject to Blue Cross claims payment policy and procedures.