BlueCross BlueShield of North Carolina

In-Network Benefit Review Request

PRIOR REVIEW/CERTIFICATION

Request for Services Fax Form

Submission of this form is solely a notification for request for services and does not guarantee approval. All requests must be reviewed using authorization requirements by the prospective review area/department before authorization is granted. *Incomplete forms may delay processing. All NC Providers must provide their 5-digit BCBSNC provider ID# below.*

Patient Name	Blue Cross NC Member ID number	Patient D.O.B.
Patient Street Address	City, State	Zip code

Requesting Provider Information		**Servicing Provider** (if different from requesting provider) **Or Facility Location** (for services to be performed outside of the physician office)	
Provider Name and Specialty		**Servicing Provider name and specialty (if different from ordering provider)**	
Provider # (or Tax ID or NPI # if No PPN)		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility # (or Tax ID or NPI# if NO PPN)**	
City/State/Zip code		**Street, Bldg., Suite # City/State/Zip code**	
Phone #		**Phone#**	
Fax #		**Fax #**	
Contact person			

ICD 10 Diagnosis Code(s):			
Other Diagnoses			
List all appropriate procedure codes (CPT, HCPCS)			

Please answer ALL questions
Fill in the appropriate response: Y= Yes ; N =No; NA = Not Applicable

If approval for In-network benefits is granted for a non-participating provider and/or facility, please note that all applicable service and procedure codes (even non-prior plan approval codes) and places of service must be requested and authorized in advance of services being performed. An approval, when granted, applies only to the provider who has been solely authorized.

In-Network Benefit Review Request
Prior Review Fax Form (page 2)

Patient Name	Blue Cross NC Member ID	Patient Date of Birth

1. **As a Non-Participating Provider and/or Facility, please provide clinical details for making a request for authorization at the member's In-network benefit level** (you may include additional pages for supporting documentation):

_____
_____
_____
_____

2. **If member is currently under your care, please provide date(s) of relevant member visit(s) within the last 12 months:**

_____

3. **For medical services that require prior authorization and certification to determine medical necessity for coverage: Do you have an existing certification or authorization for requested medical services?** Y_____N_____*

If Yes:

a. Authorization/Reference Number: _____
b. Date range of current authorization for services. From_____to _____
c. Date of next scheduled appointment. _____

***If NO**: A medical necessity coverage determination will be made at the same time as the decision for in-network benefits. Please note, decisions are distinct and may differ (i.e. prior authorization may be approved, but in-network benefits denied).

4. **For Maternity Related Requests:**

a. Estimated Delivery Date: _____
b. Current patient trimester? 1st_____ 2nd_____ 3rd_____
c. Name of facility where delivery is planned? _____

5. **Estimated date member would be able to transition to In-Network health care provider:** _____

(Please note this date is not guaranteed if your request is approved but will be subject to a mutually agreed upon transition date with Blue Cross NC and the transitioning In-Network health care provider.)

****Please include clinical documentation and medical records to support request****

PHYSICIAN ATTESTATION: By signing below, I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross and Blue Shield of North Carolina (Blue Cross NC) may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.

Physician Signature:		Date:	

Fax this form with required documentation to the appropriate fax number below:

Department	Fax Number	Department	Fax Number
Discharge Services	800.228.0838	Medical Drugs	800.795.9403
PPA/Case Mgmt/Acute Inpt	800.571.7942	SHP PPO PPA/UM	866.225.5258
Behavioral Health	866 987 4161	SHP PPO Transplant	919.765.1553

 Created: 8/18