BlueCross BlueShield of North Carolina

Laparoscopic Radiofrequency Ablation (RFA) of Uterine Fibroids: Acessa™

PRIOR REVIEW/CERTIFICATION

Request for Services 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	BCBSNC Member ID number	Patient Date of Birth

Requesting/Ordering Provider:		Servicing Provider – (interpreting/Billing Physician or Facility)	
Provider Name		Servicing Provider/ Facility Name	
Provider #, Tax ID # or NPI		Servicing provider or Facility #, Tax ID # or NPI	
Street, Bldg., Suite #		Street, Bldg., Suite #	
City/State/Zip code		City/State/Zip code	
Phone #		Phone #	
Fax #		Fax #	
Provider Contact		Provider Contact	

Primary Diagnosis		ICD-10 Code	
Other Diagnosis		ICD-10 Code	
CPT Code: _____ 58674			

Fill in the appropriate response: Y = Yes; N = No; NA = Not Applicable

	For Acessa: Is the patient eligible for and enrolled in the ULTRA Registry?
	For Sonata: Is the patient eligible for and enrolled in the ATRIUM Registry?

Fill in the appropriate response: Y = Yes; N = No; NA = Not Applicable

Does the patient have one or more of the following symptoms that are attributable to uterine fibroids?	
	Excessive uterine bleeding evidenced by profuse or prolonged bleeding? OR
	Excessive uterine bleeding evidenced by anemia due to acute or chronic blood loss? AND
The patients pelvic discomfort caused by myomata, manifests as:	
	acute severe pain? OR
	chronic lower abdominal pain? OR
	dyspareunia? OR
	bladder pressure with urinary frequency not due to urinary tract infection? OR
	low back pressure?
	Is the patient's pelvic discomfort caused by myomata with intracavitary or subserosal locations (FIGO Types 0,1, or 7)?

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By signing below, I certify that I have appropriate authority to request prior authorization and certification for the item(s) indicated on this request and that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in the patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available. Finally, I certify that I've completed this form in its entirety and I understand that an incomplete form may delay processing.
Please certify the following by signing and dating below:

Signature:		Date:	

*****PLEASE NOTE: Additional Records are NOT REQUIRED at this time IF FAX FORM CLINICAL IS COMPLETE *****

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

Department	Fax Number	Department	Fax Number
Commercial Plans	800.571.7942	State Health Plan	866.225.5258