BlueCross BlueShield of North Carolina

Request for Services

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 Provider Information		Servicing Provider Or Facility Location (for services to be performed outside of the physician office)	
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	

Place of service Home ☐ Office ☐ Outpatient hospital ☐ Inpatient hospital ☐

Specialty Pharmacy:	Home infusion:

Inpatient Services

Type of Service	Procedure Code	Date of Admission	Date of Procedure	Date of Discharge
		/ /	/ /	/ /
		/ /	/ /	/ /

Home Care

Type of Service	Procedure Code	Frequency of Services	Start Date	End Date
			/ /	/ /
			/ /	/ /

Durable Medical Equipment

Type of Service	HCPCS Code	Start Date	End Date
		/ /	/ /
		/ /	/ /

Outpatient Services

Type of Service	Procedure Code	Start Date	End Date
		/ /	/ /
		/ /	/ /

Request for Services
Prior Review Fax Form

Patient Name	BCBSNC Member ID number	Patient Date of Birth

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 BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Please certify the following by signing and dating below:

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	800.571.7942
PPA/Case Mgmt/Acute Inpt	800.571.7942	ST PPO PPA/UM	866.225.5258
	800.672.6587	ST PPO Transplant	919.765.1553
	800.459.1410	-	-