BlueCross BlueShield of North Carolina | HealthyBlue

11000 Weston Parkway
Cary, NC 27513
For Inpatient return to: **855-817-5788**
For Outpatient return to: **855-817-5788**
For Vision return to: **513-492-3259**
For Behavioral Health Inpatient: **844-439-3574**
For Behavioral Health Outpatient: **844-429-9636**

Prior Authorization Request

Prior authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The member must be Medicaid eligible and a Healthy Blue member on the date of service or date the equipment or prosthesis is received by the member. **See reverse side for instructions.**

I. General information
1. Member name:
2. Date of birth:
3. Address (Street, City, State ZIP):
4. Medicaid ID/subscriber ID:
5. Diagnosis code:
6. Diagnosis description:
7. Name and address of facility where services are to be rendered, if other than home or office:

II. Service information						**For state use only**		
8. Ref. NO.	9. Procedure code	10. From	11.Through	12. Description of service/item	13. Qty or units	Approved	Denied	Amount allowed if priced by report:
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								

https://provider.healthybluenc.com

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14. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis (Attach additional pages if necessary):

III. Provider			
15. Provider name:		16. Telephone:	
17. Address:			
18. NPI:		19. Fax:	

IV. Practitioner			
20. Name:		21. Telephone:	
22. Address:			

V. For plan use only				
Denial reason(s): Refer to field 8 above by reference numbers (Ref. NO.):				
If approved: Services authorized to begin	Date:		Reviewed by signature:	

Instructions for completion

I. **General information — To be completed by the provider requesting the prior authorization:**

1. Member's name: Enter the member's name as it appears on the Medicaid identification card.
2. Date of birth: Enter the member's date of birth.
3. Address: Enter the member's address, city, state, and ZIP.
4. Medicaid ID/subscriber ID: Enter the member's Medicaid ID/Subscriber ID number as shown on the Medicaid identification card or county letter of eligibility.
5. Diagnosis code: Enter the diagnosis code(s).
6. Diagnosis description: Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
7. Name and address of the facility where services are to be rendered, if service is to be provided other than home or office.

II. **Service information:**

8. Ref. NO.: (Reference number) a unique designator (1 to 10) identifying each separate line on the request.
9. Procedure code: Enter the procedure code(s) for the services being requested.
10. From: Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
11. Through: Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
12. Description of service/item: Enter a specific description of the service/item being requested.
13. Quantity or units: Enter the quantity or units of service/item being requested.
14. Detailed explanation of medical necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary.
    Do not use another *Prior Authorization Form*.

III. **Provider requesting prior authorization:**

15. Provider name: Enter the requested provider's information.
16. Address: Enter the complete mailing address in this field.
17. NPI: Enter the provider's NPI and taxonomy code (if applicable).

IV. **Prescribing/performing practitioner**

This section must be completed for services that require a prescription such as durable medical equipment, physical therapy, or for services that will be prescribed by a physician/practitioner that require prior authorization, or when the provider in Section III is a clinic or group practice. Check your provider manual for additional instructions:

18. Name: Enter the name of the prescribing/performing practitioner.
19. Telephone number: Enter the prescribing/performing practitioner telephone number including area code.
20. Address: Enter the address, city, state, and ZIP code.

V. **For plan use only**

Approval or denial for each line will be indicated in the box to the right of Section III. Also, in this box, the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 to 12). The consultant will sign or initial the form.