BlueCross BlueShield of North Carolina | HealthyBlue

Prior Authorization Request

Prior authorization is the approval of medically necessary services for Healthy Blue members. Prior authorization applies to the requested service(s) only and does not guarantee payment, nor does it guarantee 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 below for instructions.

Return to:

- Inpatient: **855-817-5788**
- Outpatient: **855-817-5788**
- Behavioral Health Inpatient: **844-439-3574**
- Behavioral Health Outpatient: **844-429-9636**
- Nursing Facility, IP Rehab, LTACH Services: **844-451-2694**

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

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II. Service information

9. Ref. NO.	10. Procedure code	11. Place of Service	12. From	13.Through	14. Description of service/ item	15. Qty or units
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						

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

III. Provider

17. Provider name:		18. Telephone:	
19. Address:			
20. NPI:		21. Fax:	

IV. Practitioner

22. Name:		23. Telephone:	
24. Address:			
25. Fax:			

V. Prior authorization request form completed by	
26. Contact name:	
27. Phone number:	
28. Fax number:	
VI. For plan use only	
Denial reason(s): Refer to field 9 above by reference numbers (Ref. NO.):	
If approved: Services authorized to begin	

[Date]

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. Phone number: Enter the member's telephone number.
5. 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.
6. Diagnosis code: Enter the diagnosis code(s).
7. Diagnosis description: Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
8. Name and address of the facility where services are to be rendered if service is to be provided somewhere other than home or office.

II. **Service information:**

9. Ref. No. (Reference number): Enter a unique designator (1 to 10) identifying each separate line on the request.
10. Procedure code: Enter the procedure code(s) for the services being requested.
11. Place of Service: Enter the code to indicate where the service was provided.
12. From: Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
13. Through: Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
14. Description of service/item: Enter a specific description of the service/item being requested.
15. Quantity or units: Enter the quantity or units of service/item being requested.
16. Detailed explanation of medical necessity of the service (for example, equipment/procedure/prosthesis). Attach additional page(s) as necessary and include all information required in the applicable Clinical Policy.
    Do not use another *Prior Authorization Form*.

III. **Provider requesting prior authorization:**

17. Provider name: Enter the requested provider's information.
18. Phone number: Enter the number for the requesting provider.
19. Address: Enter the complete mailing address in this field.
20. NPI: Enter the provider's NPI and taxonomy code (if applicable).

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21. Fax number: Enter the fax number for the requesting provider.

IV. Prescribing/performing practitioner

This section must be completed for services that require a prescription, such as durable medical equipment or 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:

22. Name: Enter the name of the prescribing/performing practitioner.
23. Telephone number: Enter the prescribing/performing practitioner telephone number, including area code.
24. Address: Enter the address, city, state, and ZIP code.
25. Fax number: Enter the fax number for the prescribing/performing provider.

V. Person completing *Prior Authorization Request Form*:

26. Contact name: Enter the name of the person completing the *Prior Authorization Request Form*.
27. Phone number: Enter the telephone number for the person completing the *Prior Authorization Request Form*.
28. Fax number: Enter the Fax number for the person completing the *Prior Authorization Request Form*.

VI. 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 the allowed amount if the 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.