



Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

# Prior Authorization Request Form

**Please Expedite\***

Justification for Expedited Request:

**Submit requests to:**

Fax: 866-422-5120

Phone: 877-399-1671

If no justification given, request will be processed as standard

\*Please ONLY check this option if the provider believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy (CMS definition)

## 1. Member Information & Background

Patient Name: \_\_\_\_\_ Previous auth # (if applicable): \_\_\_\_\_

Member/Patient ID Number: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_ Pt. phone: \_\_\_\_\_ Contact Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Requesting Provider: \_\_\_\_\_

\_\_\_\_\_ Requesting Provider NPI#: \_\_\_\_\_

ICD10Code(s): \_\_\_\_\_ Treating Provider: \_\_\_\_\_

CPT/HCPCS Code(s): \_\_\_\_\_ Treating Provider NPI#: \_\_\_\_\_

Date of Admission/Procedure: \_\_\_\_\_ TBD *Inpatient requests, include these providers:*

Type: IP Hospital Office Surgery DME Admitting Provider: \_\_\_\_\_

OP Diagnostics OP Surgery/ASC Admitting Provider NPI#: \_\_\_\_\_

# Visits/Units/Days: \_\_\_\_\_ Servicing Facility: \_\_\_\_\_

Authorization Date Span: \_\_\_\_\_ - \_\_\_\_\_ Svc Facility NPI#: \_\_\_\_\_

For inpatient services only: If overnight admission is planned, please provide justification (e.g. procedure on CMS inpatient only list). **Note:** Must specify IP admission with appropriate code in CPT Code field above or services are assumed & reviewed as OP setting.

Comments:

**This form must be filled out completely. Chart notes are required and need to be submitted with this request. Incomplete requests will be returned to the requester.**

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