REFERRAL OR PRECERTIFICATION REQUEST

FAX FORM (PCP Coordinated Care HMO Plans only)

Fax to BCBSAZ PCP Coordinated Care HMO Plans at: 1 (844) 263-2272

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Type of request (select one):

☐ **PCP Referral to Specialist** – only complete sections 2 through 5 on page 1 of this form. SAVE and FAX to 1 (844) 263-2272.

☐ **Precertification Request** – all of the following information and documentation is required. Incomplete forms will be returned for additional information. SAVE and FAX to 1 (844) 263-2272.

1. PRECERTIFICATION PRIORITY

☐	a. Standard	Elective admission or services to be scheduled within 30 days (precert date ranges may vary).
☐	b. Date Certain	Elective admission or services already scheduled for this date (within 30 days):
☐	c. Urgent	Provider certifies that applying the standard review time frame may seriously jeopardize the member's life, health, or ability to recover, or result in serious impairment or permanent disability.

2. PATIENT INFORMATION

Patient Name (First):	Last:	MI:
Patient DOB (mm/dd/yyyy):	Member ID # (including prefix):	Group # on ID Card:
Patient's Designated or Covering PCP:	PCP Contact Name:	
PCP Phone:	PCP Fax:	

3. ORDERING PHYSICIAN ☐ Same as Designated or Covering PCP (see #2 above)

Physician Name:	TIN: NPI#:	Specialty:	Contact Name:
Group Name:		Group Address:	
City, State, Zip:		Phone:	Fax:

4. SPECIALIST/CLINIC/FACILITY/PHARMACY PROVIDER to provide requested service/treatment/medication

Specialist Name:	TIN: NPI#:	Specialty:	Contact Name:
Group/Facility Name:		Address:	
City, State, Zip:		Phone:	Fax:

5. REQUESTED MEDICAL SERVICE/PROCEDURE/COURSE OF TREATMENT/DEVICE INFORMATION

☐ **PCP-to-Specialist Referral** – covers all office services rendered by specialist or covering provider (in same specialty and tax ID) that do not require precert, for up to 1 year

☐ **Precertification Request** – please indicate Coding, Place of Service, and Type of Service specifics below

ICD-10:	ICD-10 Description:

Place of Service: ☐ Office ☐ Outpatient ☐ Inpatient ☐ Home ☐ *Other

*Please specify if other:

Type of Service (check applicable boxes):

☐ Elective Inpatient Admission	☐ Air Ambulance (Non-Emergent)	☐ Out of Network	☐ Medical Foods/Nutritional Supplements
☐ Emergency Admission	☐ Retail & Mail-order Rx Meds	☐ DME	☐ Genetic Testing
☐ LTAC	☐ Home Health	☐ Infertility	☐ Outpatient Therapy (PT, OT, & ST)
☐ SNF	☐ Behavioral/Mental Health	☐ Dental	☐ Outpatient Testing/Procedure
☐ Transplant Request	☐ Clinical Trials	☐ Orthognathic Surgery	☐ Diagnostic Imaging (MRI/MRA/PET/CAT/CTA)

For precertification requests, please also complete sections 6 – 9 on page 2 of this form.

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6. HCPCS/CPT/CDT CODES

HCPCS/CPT/CDT Code	Code Description	Medical Reason	Frequency Requested

Other Clinical Information – Include/attach clinical/office notes, laboratory information, imaging reports, and any other necessary information to support medical necessity. If this is a request for out-of-network services, please provide an explanation.

7. OTHER SERVICES (Requiring precertification such as DME, Home Health, Therapy)

Type of Service:		Name of Therapy/Agency:
Units/ Visits Requested:	Frequency/Length of Time Needed:	☐ Initial ☐ Extension Previous Precertification #:
Additional Comments:		

8. PRESCRIPTION DRUG

Diagnosis name and code:

Medication Requested	Strength	Dosing Schedule	Quantity Per Month

Is the patient currently treated with requested medication(s): ☐ Yes ☐ No
If yes, when was treatment with the requested medication started?

Explain the medical reason for requested medication, including an explanation for selecting this medication over alternatives:

List any other medications patient will use in combination with requested medication:

9. PREVIOUS SERVICES/THERAPY (INCLUDING DRUG, DOSE, DURATION)

a.	Date:
b.	Date:
c.	Date:
d. Reason for discontinuing previous therapy (e.g. contraindications, allergies, therapeutic failure):	

Additional Information – Please attach and submit any progress notes, lab data, discharge summaries, or other relevant documentation to support discontinuation of previous therapy.

SAVE and FAX this form to BCBSAZ PCP Coordinated Care HMO Plans at 1 (844) 263-2272 | For questions, call 1 (844) 807-5106

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