Capital BLUE

# Preauthorization Letter of Medical Necessity

*Fax completed form to: 717.540.2171*

*To ensure accurate and timely processing of your request, please complete all fields on the form.*

**SECTION I—Member Information**

| | | | | |
|---|---|---|---|---|
| Member Name: | | Member ID: | | Date of Birth: |
| Plan Type: | ☐ Traditional | ☐ BlueJourney PPO | ☐ PPO | ☐ Comprehensive |
| | ☐ BlueJourney HMO | ☐ POS | ☐ Keystone Health Plan® Central, Inc. | |
| Does member have other primary insurance? ☐ N/A ☐ Workers' Comp ☐ Auto ☐ Other: | | | | |

**SECTION II—Authorization**

Authorization Type: ☐ Initial Authorization ☐ Reauthorization (Subsequent) ☐ Prior Authorization #:

Level of Urgency:

☐ **Standard** Request (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature.

☐ **Expedited** Request—Care/treatment that is emergent or the application of the timeframe for making Standard/Routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

**For Expedited Request, Please Explain:**

| | | |
|---|---|---|
| Admission Date: | End Date: | Requested Units/Days: |
| Primary Diagnosis: | Additional Diagnosis: | |
| All Procedure/HCPC Code(s): | | |
| Place of Service: ☐ MD Office ☐ Hospital ☐ Clinic ☐ Inpatient ☐ Outpatient ☐ Other: | | |

**SECTION III—Servicing/Performing Provider Information**

| | |
|---|---|
| Name: | Provider NPI: |
| If Service/Procedure is being done in a Facility, name of Facility: | Facility NPI (if known): |
| ☐ Local Blue Plan (if yes, please provide Local Blue Plan identification) | |
| Servicing Address: | |

| | | |
|---|---|---|
| Servicing City: | Servicing State: | Servicing ZIP Code: |
| Contact Name: | Contact Phone: | Fax: |

**SECTION IV—Referring Provider Information (if different than above)**

| | | |
|---|---|---|
| Referring Provider Name: | | Requesting Provider NPI: |
| Address: | | |
| City: | State: | ZIP Code: |
| Contact Name: | Contact Phone: | Fax: |

**SECTION V—Additional Information (Required)**

☐ Fax along with this cover sheet the initial evaluation or progress notes, and any additional Clinical documentation related to this request.

- Photo(s) Enclosed: ☐ Yes ☐ No ☐ Emailed ☐ Faxed
- Molds: ☐ Yes ☐ No Date Sent:

| | |
|---|---|
| Any questions, contact Capital BlueCross Preauthorization department at 800.471.2242 | Capital BlueCross Letter of Medical Necessity Mailing Address<br>UM Department Capital BlueCross<br>PO Box 773731<br>Harrisburg, PA 17177-3731 |

**SECTION VI—Physician Signature**

| | |
|---|---|
| Please Sign: | Date: |

*(Preauthorization is not a guarantee of payment.)*