Capital BLUE

Preauthorization Inpatient Elective Admission

Fax completed form to: 717.651.8966

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

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:	
Primary Procedure/HCPC Codes:		

Place of Service: ☐ MD Office ☐ Hospital ☐ Clinic ☐ Inpatient ☐ Outpatient ☐ Other:

SECTION III—Servicing 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

☐ Please attach to this cover sheet the most recent H&P, progress notes, diagnostic studies, and any other 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 UM Department Capital BlueCross PO Box 773731 Harrisburg, PA 17177-3731

SECTION VI—Physician Signature

Please Sign:	Date:

(Preauthorization is not a guarantee of payment.)