

# Preauthorization inpatient elective admission



**Inpatient hospital admission** – Procedures considered inpatient only per CMS guidelines (Medicare Advantage members only) or InterQual guidelines (Commercial members only). Preauthorization is required for these requests.

**Observation hospital admission** – Procedures that can be completed with up to 48 hours of an observation level stay in the hospital. Preauthorization is not required for these requests.

Fax completed form to: **717.651.8966**

Section I: Member information		
Member name:	Member ID:	Date of birth:
Product: <input type="checkbox"/> CHIP <input type="checkbox"/> Commercial <input type="checkbox"/> FEP <input type="checkbox"/> Medicare Advantage		
Does member have other primary insurance? <input type="checkbox"/> N/A <input type="checkbox"/> Workers' comp <input type="checkbox"/> Auto <input type="checkbox"/> Other:		
Section II: Authorization		
Level of urgency:		
<input type="checkbox"/> <b>Standard</b> request (routine care)—Care/treatment that is not emergent, urgent, or preventive in nature.		
<input type="checkbox"/> <b>Expedited</b> request—Care/treatment that is emergent or the application of the timeframe for making standard/routine or not life-threatening care determinations:		
<ul style="list-style-type: none"><li>• Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or</li><li>• 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.</li></ul>		
For expedited request, please explain:		
Section III: Clinical summary		
Place of service: <input type="checkbox"/> Hospital <input type="checkbox"/> Other:		
Admission date:	End date:	Requested units/days:
Primary diagnosis:	Additional diagnosis:	
Primary procedure/HCPC codes:		
**All pertinent clinical information must be included.**		
Section IV: 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):		
Address:		
City:	State:	ZIP Code:
Contact name:	Contact phone:	Fax:
Section V: Requesting provider information (if different than above)		
Name:	Provider NPI:	
Address:		
City:	State:	ZIP Code:
Contact name:	Contact phone:	Fax:
Section VI: Additional information		
To prevent delay of this review, please include all pertinent clinical information such as:		
<input type="checkbox"/> Most recent H&P.	<input type="checkbox"/> Progress notes.	<input type="checkbox"/> Diagnostic studies. <input type="checkbox"/> Photo(s). <input type="checkbox"/> Molds.
Any questions, contact Capital Blue Cross Preauthorization department at <b>800.471.2242</b>	Capital Blue Cross letter of medical necessity mailing address UM department Capital Blue Cross PO Box 773731 Harrisburg, PA 17177-3731	
Section VII: Physician signature		
Please sign:	Date:	

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

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