PRIOR AUTHORIZATION GENERAL REQUEST FOR ELECTIVE SURGERY, PROCEDURE, SERVICE OR DME (ACA MEMBERS)

* Required Field

Enter Patient Information

Review Type:

Blue KC ID (Not SS#): * - -

Patient First Name: *

Patient Middle Initial:

Patient Last Name: *

Date of Birth: *

Patient Group ID: *

IDC-10 Diagnosis Codes: * Diagnosis Codes must be 3-8 characters along with decimals

CPT or HCPCS Codes: * (Include modifiers if applicable) CPT/HCPCS codes must contain 5-9 characters

Units may contain up to 3 characters

Units:

High Tech Radiology authorizations may go through eviCore. Please call for benefits prior to submission.

Date of Service/Admission Date: *

Procedure is scheduled as: *

- ☐ 23-hr observation
- ☐ Outpatient
- ☐ Inpatient

* Required Field

Enter Provider Information

Contact First Name: *

Contact Last Name: *

Contact Email Address:

Contact Phone No:*

Contact Phone Ext:

Contact Fax No:*

Provider ID OR NPI: *

- ☐ I am an Ordering Physician
- ☐ I am a Servicing Physician

Ordering Physician/Provider Name: *

Ordering Physician's Address: *

Ordering Physician's City: *

Ordering Physician's State: *

Ordering Physician's Zip: *

Ordering Physician's Email Address:

Ordering Physician's Phone No:

Ordering Physician's Fax No:

Servicing Physician's Name:

Servicing Physician's Address:

Servicing Physician's City:

Servicing Physician's State:

Servicing Physician's Zip:

Servicing Physician's Email Address:

Servicing Physician's Phone No:

Servicing Physician's Fax No:

Facility/Supplier Name: *

Facility NPI:

Facility/Supplier Address: *

Facility/Supplier City: *

Facility/Supplier State: *

Facility/Supplier Zip: *

Proposed Intervention:

History of condition (including duration of condition, previous failed conservative treatments, etc.): *

Signs and symptoms that justify the intervention (such as ominous characteristics of a lesion—size, shape, pigmentation and growth changes, failure of conservative treatments, complication of the current management plan, etc.): *

Durable Medical Equipment (DME)

☐ New ☐ Replacement

☐ Other

Submit this completed Prior Authorization form and all relevant supporting documentation:

By Fax

877-549-1744

By Mail

Blue Cross and Blue Shield of Kansas City

Central Operations (COPS) Blue KC MA & ACA

P.O. Box 419169

Kansas City, MO 64141