Kansas City

Prior Authorization General Request for Elective Surgery, Service or DME

*** Required Field**

Enter Patient Information

Patient Group ID: *

Review Type: * ◯ Standard ◯ Expedited

Procedure is scheduled as: * ◯ Outpatient ◯ Inpatient

Treatment Type: * ◯ Maternity Medical ◯ Pediatric Medical ◯ Pediatric Surgical ◯ Medical ◯ Surgical

Date of Service / Expected Admission Date: *

Frequency / Length of Time Needed: *

Start Date: *

End Date: *

ICD-10 Diagnosis Code: *

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.

Devices Planned for Use:

Blue KC ID (Not SS#): *

Prefix:

Member ID:

Suffix:

Patient First Name: *

Patient Middle Initial:

Patient Last Name: *

Date of Birth: *

* 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: *

Requesting Physician/Provider Name:

Requesting Physician/Provider NPI: *

Requesting Physician's Address: *

Requesting Physician's City: *

Requesting Physician's State: *
(use 2-digit code)

Requesting Physician's Zip: *

Requesting Physician's Email Address:

Requesting Physician's Phone No:

Requesting Physician's Fax No: *

Servicing Physician's Name:

Servicing Physician's NPI: *

Servicing Physician's Address: *

Servicing Physician's City: *

Servicing Physician's State: (use 2-digit state code) *

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: *
(use 2-digit state code)

Facility/Supplier Zip: *

Proposed Intervention: *

** Please provide name of service or procedure to be performed as well as anatomical site. If spinal surgery, please provide level(s).

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

Please include relevant clinical documentation. *