

REQUEST FOR PRIOR AUTHORIZATION FOR SERVICES AND PROCEDURES

Please fax this completed form **along with all pertinent clinical documentation** to BlueChoice HealthPlan at 800-610-5685. Allow three business days for return confirmation of authorization. You can now request authorizations for some procedures/services on our website at BlueChoiceSC.com. See a list of these in the 2011 Physician Office Administrative Manual.

Your Name: _____

Practice's Name: _____

Practice's Phone: _____ **Practice's Fax:** _____

Total Number of Pages in Fax Including Cover Page: _____

Please tell us about the patient and the referral.

Patient's Name: _____

BlueChoice HealthPlan ID#: _____ **Date of Birth:** _____

Requesting Physician: _____ **Tax ID:** _____

Diagnosis: _____

Planned Service/Procedure Name/ICD 9 Code(s): _____

**Please Direct Radiology Service Requests to National Imaging Associates (NIA)*
at 888-642-9181 or www.RadMD.com**

*NIA provides utilization management services of certain radiological procedures. NIA is an independent company.

Facility's Name: _____

Inpatient** **Number of Days Requested:** _____ Outpatient Office

Date Planned: _____ **Number of Follow-Up Visits Needed:** _____

****BlueChoice HealthPlan considers 23-hour observation as a one-day inpatient length of stay.**

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BlueChoice HealthPlan Use Only

Authorization #: _____ **New Date Range:** _____

Today's Date: _____ **BlueChoice HealthPlan Staff's Initials:** _____