

**MEDICAL SERVICE and BEHAVIORAL HEALTH
Prior Authorization Form**

FAX: 1-877-424-5680

www.HealthChoicePathway.com



An Independent Licensee of the Blue Cross Blue Shield Association

**Health
Choice**

Ordering Providers are required to send medical documentation supporting the requested service.

Member Name (Last, First)	Member ID#	DOB	Date of Request
Ordering Provider Name and Address	NPI#	TIN#	
Office Contact Person	Direct Phone #	Fax#	
Diagnosis 1 (ICD-10 code)	Diagnosis 2 (ICD-10 code)	Diagnosis 3 (ICD-10 code)	

• STANDARD (up to 14 calendar days) ... No Signature Required.
• EXPEDITED (up to 72 hours) ... By signing below, you are requesting expedited processing and that the request fits into one of the two categories below.

- Processing within the standard timeframe will jeopardize the life or health of the member and impact ability to regain maximum function.
- Processing within the standard timeframe will cause a barrier to transition of care

Therefore, you are certifying, as the ordering provider, that applying the standard review time frame may seriously jeopardize the member's life, health, or ability to regain maximum function.

Ordering Provider Signature	Date
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<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> ASC <input type="checkbox"/> Office	Specialist Name (Last, First)	Specialty
Name of Facility/Office		Date of Service	
Address	NPI#	TIN#	Phone #
Name of Service/Item		CPT/HCPC _____ _____ # of visits/units	CPT/HCPC _____ _____ # of visits/units
CPT/HCPC _____ _____ # of visits/units	CPT/HCPC _____ _____ # of visits/units	CPT/HCPC _____ _____ # of visits/units	CPT/HCPC _____ _____ # of visits/units

PLEASE NOTE - ALL IMAGING SERVICES requiring Prior Authorization should be directed to the BCBSAZ Health Choice Radiology Benefits Manager **eviCore** (Phone 1-888-693-3211) per the Prior Authorization Manual.

Medication Request for Administration for Physician Office Administration

Name of Medication (and J-code)	Dosage	Quantity/Amount	Refills (<12)
Sig/Instructions		Please choose one: <input type="checkbox"/> Buy and Bill <input type="checkbox"/> CVS Specialty Pharmacy	
List Medications Tried/When			
List Medications Contraindicated/Reason			
Provider Signature			Date