CareFirst BlueChoice | CareFirst BlueCross BlueShield

Pre-Service Review Request for Authorization Form

(For services that require prior elevated nurse/medical review ONLY)

INSTRUCTIONS

Please complete all fields and attach clinical documentation to support the medical necessity of the service(s) requested (i.e., letter of medical necessity, office notes, test results and/or treatment plans). This will enable us to reply to you efficiently and in a minimal amount of time. Incomplete information may delay processing of your request. Please allow 3-5 business days for review of your authorization. For artificial insemination (AI) or In-vitro Fertilization (IVF), please use the Infertility Pre-Treatment Form. Outpatient rehabilitation: Use the Outpatient Pre-Treatment Authorization Program Form. For services that do not require prior nurse review, use the Precertification Messages Request form and fax to 410-781-7661, or call Precertification at 1-866-PRE-AUTH (773-2884), option 1.

Participating Providers: To check the status of the authorization, visit CareFirst Direct at **www.carefirst.com**.

For services that require nurse review, fax this form to the appropriate pre-service review number below:	
Inpatient Services	410-720-3058
Outpatient Services (for BlueChoice HMO level benefits)	410-720-3060
Transplants	410-720-3061
Bariatric Surgery	410-720-3062
Orthognathic Surgery	410-720-3063
***Outpatient services for Federal Employee Program (FEP)** (Member number starts with single letter "R")	410-720-5322

**Outpatient prior authorization for FEP members is limited to surgery for morbid obesity, IMRT, accidental injury to the jaws, cheeks, lips, roof or floor of the mouth or surgery to correct a congenital anomaly. For prior authorization of services related to life-threatening illness, please contact FEP provider services at 1-800-854-5256 or 202-488-4900.*

Provider Information

Provider's Name		Date (mm/dd/yy)
Phone Number	Fax Number	Tax ID
Office Contact's Name		Phone Number (including extension)

If services are to be provided by another provider or vendor, please list the full name, address and phone number below. If requesting Out-of-Network services for a BlueChoice member, please submit a letter of medical necessity explaining why services cannot be provided In-Network.

Provider's Name	Phone Number
Provider's Address	

Member/Patient Information

Member Name	Member Number	DOB (mm/dd/yy)

Treatment Information

Date(s) of service or admit date. If service involves multiple visits over a period of time, please specify number of visits and date span requested.

Dates of Service/Admit	Number of Visits

Place of Service (check one): ☐ Inpatient ☐ Outpatient ☐ Office ☐ Patient's Home

Diagnosis and diagnosis code(s) (ICD-9)

Procedure and procedure code(s) (CPT-4 or HCPCS):

If services are part of a clinical trial, please submit a letter of medical necessity signed by the treating physician, the trial protocol identifying the trial phase, IRB # and approving body.

Hospital/Facility full name (Please include full address and phone number below if out of state or non-participating facility.):

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