

CareFirst BlueCross BlueShield Pre Service Review Request for Authorization Form

Please complete all fields and attach clinical documentation to support the medical necessity of the service(s) requested, such as a 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. Participating providers should check the status of the authorization at CareFirst Direct. Please allow three to five business days after you have submitted all requested information to allow for review of your authorization request. For AI or IVF use the Infertility Pre-Treatment Form. For outpatient rehabilitation use the Outpatient Pre-Treatment Authorization Program Form.

Please fax authorization requests to PreService Review at:

Inpatient Services	Outpatient Services	Transplants	Bariatric Surgery	Orthognathic Surgery	** Outpatient Services for Federal Employees (FEP): Member number starts with single letter "R"
410-720-3058	410-720-3060	410-720-3061	410-720-3062	410-720-3063	410-720-5322
** Outpatient prior authorization for FEP members is limited to surgery for morbid obesity, accidental injury to the jaws, cheeks, lips, tongue, 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 provider services.					
Provider Information					
Provider's full name:					Date:
Phone #		Fax #		Tax ID	
Office contact's name and direct phone number with extension:					
If services are to be provided by another physician or vendor, please provide full name and phone number (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):					
Member/Patient Information					
Member #		Member Name			DOB:
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.					
Place of service (circle 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 if out of state or non-participating facility):					
Hospital/Facility full address and phone number (if not participating or out of state):					