

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.

Please fax authorization requests to PreService Review at:

AI and IVF	Inpatient Services	Outpatient Services	Transplants	Bariatric Surgery	Orthognathic Surgery
410-505-6884	410-720-3058	410-720-3060	410-720-3061	410-720-3062	410-720-3063
Provider Information					
Provider's full name:					Date:
Phone #:		Fax #		Tax ID	
Office contact's name and direct phone number or 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 from the treating physician, the trial protocol identifying the trial phase, IRB # and approving body):					
Hospital/Facility full name:					
Hospital/Facility full address and phone number (if not participating or out of state):					
(for internal use only)					
Associate Name:			Authorization / Reference #:		
Date(s) additional information requested:		Date notice of review extension faxed:		Date Completed:	