BlueCross BlueShield of Mississippi

It's good to be Blue.

Prior Authorization Request

Please fax to:
Attention: BCBSMS Care Management
601-664-5044

This form must be completed in its entirety. All pertinent medical necessity documentation (i.e. treatment plan, history and physical, progress notes, treatment rendered, proof of patient compliance with treatment, tests performed, labs results, radiology reports) must be submitted with this request.

This form can also be used to submit a Pre-Determination of Benefits Request for State Health Plan Participants and an Advanced Benefit Determination for Federal Employee Program Members.

Submission Date:_____

Patient Information

Name:_____ Date of Birth:_____

BCBS ID:_____ Phone Number:_____

Ordering Provider Information

Provider Name:_____ NPI:_____

Address:_____

City, State, Zip:_____

Contact Person:_____ Title:_____

Phone:_____ Fax:_____

Servicing Provider Information

Provider Name:_____ NPI:_____

Address:_____

City, State, Zip:_____

Phone:_____ Fax:_____

Diagnosis and Clinical Information

Date(s) of Service:_____

ICD Diagnosis Codes:_____

Procedure Codes:_____

Service Description:_____

I certify that all pertinent medical necessity documentation is attached. I certify that this treatment/service is necessary for this patient, and I will be supervising the patient's treatment accordingly. I acknowledge by signing this form that the information contained within is correct, and I also acknowledge that my records are subject to audit by Blue Cross & Blue Shield of Mississippi.

_____ _____

Ordering Provider Signature Date

Prior authorization is a determination of medical necessity. It is not a guarantee of payment or that the member's contract will be in effect at the time services are rendered.