BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization/Predetermination Request

Please **fax** completed forms to **(816)502-4910**
If you have any questions please call (816)395-3989

Patient's Name	Physician's Name	
BCBSKC ID (NOT SS#):	Date of Service	
BCBSKC 8-digit Provider # or NPI#	Facility	
Contact Name	Contact Fax No.	Contact Phone No.

Proposed surgery, procedure or service: ___Outpatient ___23-hr observation ___Inpatient

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CPT or HCPCS Codes: ____________ ____________ ____________ ____________

History of condition (including duration of condition, previous failed conservative treatments, etc.):___________

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Signs and symptoms that justify the intervention (such as ominous characteristics of a lesion—size, shape, pigmentation and growth changes, failure of conservative treatments, complication of the current management plan, etc.):____

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Current diagnosis:____

ICD-9 Codes ____________ ____________ ____________ ____________

For BCBSKC Use Only

BCBSKC Reference Number:___________________________ # of Days or Units Approved:_______________

Medical Management Team Member Name:____

Please allow two (2) business days from date of receipt of all necessary information for determination.
Duplicate submissions slow the process.

All patient information is strictly confidential.
Incomplete forms will be returned.