



South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Precertification Request Form - Confidential -

Date Submitted: _____

Complete this form to request precertification for a specific procedure/service. If the determination of this review will influence the decision to proceed with treatment, we recommend that you do not schedule treatment until we issue the final decision.

A request for precertification is not necessary for urgent or emergency medical treatment. If a medical review is necessary, please allow up to 15 days for a decision to be made.

Return completed form to: ATTN: Focus Review/Health Care Services I-20 @ Alpine Road, AX-630 Columbia, SC 29219-0001

You can also fax the completed form to (803) 264-0258. If you have any questions, please contact Provider Services at 1-800-868-2510, Monday through Friday, 8:00 a.m. to 8:00 p.m. (ET).

Member's Name: _____ Member's ID Number: _____ Date of Birth (mm/dd/yy): _____ [] Male [] Female Diagnosis (including ICD-9-CM Code): _____

Requested Procedure(s) or Equipment: _____ *CPT ®† or HCPCS Codes (required): _____

Please submit photographs if requesting precertification for one of the following procedures:

- Blepharoplasty (include visual fields) Otoplasty Scar Revision Hemiangoma Abdominoplasty (include height and weight) Rhinoplasty Mammoplasty Varicose Veins

Note: Please do not fax photographs. Mail photographs to the Focus Review address. All mailed photographs must include the patient's name and policy ID number.

Indicate clinical information to support medical appropriateness (e.g., failed outpatient therapy, laboratory or X-ray results, vital signs), medications, presenting symptoms, plan of treatment and brief clinical history:

Please attach additional supporting documentation (e.g. X-rays, pictures, Certificate of Medical Necessity).

[] Attachment(s) [] No Attachment(s)

You can access BlueCross BlueShield of South Carolina Medical Policies online at www.southcarolinablues.com/BCBS/bcbs_prov1.nsf#.

**Physician: _____ Provider No.: _____ Phone No.: _____ Address: _____ NPI No.: _____ Fax No.: _____ **Facility/Supplier: _____ Provider No.: _____ Phone No.: _____ Address: _____ NPI No.: _____ Fax No.: _____

** If provider, facility or supplier is out-of-network and requesting in-network benefits, please note and attach the rationale for utilizing out-of-network sources.

Please note: Although precertification approvals are valid for one year, final reimbursement determinations are based on member eligibility at the time of service, medical necessity criteria, applicable member copayments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and BlueCross BlueShield of South Carolina medical policy.

© Registered marks of the Blue Cross and Blue Shield Association.

©†Registered mark of the American Medical Association.