Blue Cross Community Family Health Plan℠

FOR INTERNAL USE ONLY
UMC
(Work Item Type)

Please write clearly or complete on-screen, then print and fax to:
1-312-233-4060

Preauthorization Request

☐URGENT (If checked, please provide anticipated date of service below)

_____

Please attach supporting documentation to facilitate your request (e.g., the history & physical, letter of medical necessity, original photographs, etc.) This form must be placed on top of the information you are submitting.

Member/Patient Data:	
Identification Number: *(Include the three-digit prefix)*	Group #
Member's Name:	Date of Service:
Patient's Name:	Date of Birth:
Procedure Codes:	
Diagnosis Codes (if a medical service only) *(List primary first)*	CPT4/HCPC codes(s) include unit of measure/frequency for supplies & services
Services Rendered	Please check one of the boxes below: ☐ Provider Office ☐ Outpatient Facility ☐Inpatient Facility Office or Facility Name: _____ Address: _____ Phone: _____ National Provider Identifier (NPI) Number(s) _____
Please attach or include any additional supporting clinical information in the space below.	

Provider Data:	
NPI Number(s)(if applicable)	Today's Date:
Physician/Professional Provider Name	
Address:	