



# Blue Cross Community Family Health Plan<sup>SM</sup>

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:

<b>Identification Number:</b> <i>(Include the three-digit prefix)</i>		Group #
Member's Name:	Date of Service:	
Patient's Name:	Date of Birth:	
Procedure Codes:		
Diagnosis Codes (if a medical service only) <i>(List primary first)</i>		CPT4/HCPC codes(s) include unit of measure/frequency for supplies & services

Services Rendered	Please check one of the boxes below: <input type="checkbox"/> Provider Office <input type="checkbox"/> Outpatient Facility <input type="checkbox"/> Inpatient Facility Office or Facility Name: _____ Address: _____ Phone: _____ National Provider Identifier (NPI) Number(s) _____
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Please attach or include any additional supporting clinical information in the space below.

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### Provider Data:

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

Confidentiality Note: The information contained in this facsimile message is privileged and confidential and is intended only for the exclusive information and use of the addressee. If you are not the intended recipient, any copying, use or distribution is unauthorized. If you are responsible for delivering this message to the addressee, it may not be copied, used, or distributed except as directed by the addressee. If you have received this message in error, please notify us immediately by telephone so that we can arrange for its return to us at no cost to you.

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