BlueCross BlueShield of Illinois

FOR INTERNAL US ONLY
UMC
(WORK ITEM TYPE)

Medicaid Prior Authorization Request Form

Please fax completed form to 312-233-4060

This information applies to Blue Cross Community Health Plans℠ (BCCHP℠) and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ members.

☐ **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	
ID # (INCLUDE THREE-CHARACTER PREFIX):	GROUP #
MEMBER NAME	DATE OF SERVICE
PATIENT NAME	DATE OF BIRTH
PROCEDURE CODE(S)	
DIAGNOSIS CODE(S) (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: ☐ PROVIDER OFFICE ☐ OUTPATIENT FACILITY ☐ INPATIENT FACILITY
	OFFICE OR FACILITY NAME
	ADDRESS/CITY/STATE/ZIP
	PHONE
	NPI(S)

PLEASE ATTACH OR INCLUDE ANY ADDITIONAL SUPPORTING CLINICAL INFORMATION IN THE SPACE BELOW.

PROVIDER DATA	
NPI, IF APPLICABLE	DATE
PHYSICIAN/PROFESSIONAL PROVIDER NAME	
ADDRESS/CITY/STATE/ZIP	