# FEP Generic Prior Approval Request/Response

Fax to Care Management:
800-843-1114

Blue Cross Blue Shield
Federal Employee Program
PO Box 327
Seattle, WA 98111-0327
877-342-5258

BlueCross BlueShield
Federal Employee Program

**Request date:**

☐ **Expedited** - All requests being marked as expedited must include supporting documentation from the physician's office that the request is related to service(s) or treatment(s) as follows: **a)** the service or treatment is potentially life- or limb-saving (e.g. chemotherapy, possibly some other pharmaceutical agent) when there is an expressed time of treatment (schedule) requirement; or, **b)** in the opinion of the physician, with knowledge of the member's medical condition, a diagnostic test that could directly affect an immediate decision to render a life- or limb-saving treatment. **Please contact our physician and provider line at 877-342-5258, option 2, for eligibility and benefit information.**

**Member/patient** _____ Date of birth _____

Subscriber/policy holder name _____

Member ID R_____ Suffix _____ Group number _____

**REQUESTING PROVIDER** _____

Facility/practice name _____

Address _____

City/State/ZIP _____

Tax ID/NPI number _____

Phone _____ Fax _____

Contact person _____

**SERVICING PROVIDER** _____

Address _____

City/State/ZIP _____

Phone _____ Fax _____

Contact Person _____

Tax ID/NPI number _____

Contracted provider: ☐ Yes ☐ No

| Procedure/CPT Code | ICD Code | Modifier | Unlisted Code Description |
|---|---|---|---|
| | | | |
| | | | |

**Clinical Information – Attach supporting medical records and include presenting symptoms and previous treatment.**

☐ Outpatient ☐ Inpatient Facility name _____

Date scheduled _____ Facility address, city, state, and ZIP _____

If submission of this form is more than seven days post-service, medical necessity will be reviewed upon submission of the claim.

**For Care Management Use Only**

☐ Yes – Meets medical necessity criteria ☐ Modified ☐ No – See comments below

Reference # _____ ☐ No screening required

| Procedure/CPT | Prior Approval Date Span | | Screened by / Reviewed by: |
|---|---|---|---|
| | From: | To: | |
| | From: | To: | |
| | From: | To: | |

**Letter to follow because service(s):**

☐ Did not meet medical necessity criteria ☐ Met medical necessity criteria
☐ Not a contract benefit ☐ No response to request for additional information
☐ Member not eligible ☐ Investigational/experimental

Comments: