

# 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 _____
<b>REQUESTING PROVIDER</b> _____	<b>SERVICING PROVIDER</b> _____
Facility/practice name _____	Address _____
Address _____	City/State/ZIP _____
City/State/ZIP _____	Phone _____ Fax _____
Tax ID/NPI number _____	Contact Person _____
Phone _____ Fax _____	Tax ID/NPI number _____
Contact person _____	Contracted provider: <input type="checkbox"/> Yes <input type="checkbox"/> No

Procedure/CPT Code	ICD Code	Modifier	Unlisted Code Description

<b>Clinical Information – Attach supporting medical records and include presenting symptoms and previous treatment.</b>	
<input type="checkbox"/> Outpatient <input type="checkbox"/> 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):

- |  |  |
|--|--|
| <input type="checkbox"/> Did not meet medical necessity criteria | <input type="checkbox"/> Met medical necessity criteria                    |
| <input type="checkbox"/> Not a contract benefit                  | <input type="checkbox"/> No response to request for additional information |
| <input type="checkbox"/> Member not eligible                     | <input type="checkbox"/> Investigational/experimental                      |

Comments:

**Note:** This prior approval is a determination of medical necessity and is limited to 90 days, unless otherwise specified. Please note that this is **not** a guarantee of payment. This prior approval is based on diagnosis and medical information submitted and is subject to all contract terms, including, but not limited to, member benefits, benefit maximums and subscription charge payment covering dates of service. Unless specifically requested elsewhere in this document, please do not send a DNA or other genetic sample, or the results of any genetic typing, test or analysis, including DNA. **Confidentiality Notice:** The information contained in this facsimile message is privileged or confidential, and intended only for the individual or entity named above. If the reader is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone at the number listed on this page.