



P R O M I S E

<b>Treatment Authorization Request</b>		<b>Circulating Tumor DNA and Circulating Tumor Cells for Cancer Management (Liquid Biopsy)</b>	
<b>Standard Fax Number:</b> (323) 889-6506		<b>Urgent Fax Number:</b> (323) 889-5403	
Use AuthAccel - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection ( <a href="http://www.blueshieldca.com/provider">www.blueshieldca.com/provider</a> ) and click the Authorizations tab to get started.			
<b>Notice: Blue Shield of CA has a 5 Business Day turn-around time on all Standard Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.</b>			
<input type="checkbox"/> <b>New Standard Request</b> <input type="checkbox"/> <b>New Urgent Request</b> <input type="checkbox"/> <b>Retro Request</b> <input type="checkbox"/> <b>Standing Referral</b>			
<b>Important For Urgent Requests:</b> Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. <i>If there is no MD signature present, the request will be processed as a Standard request.</i>			
<b>MD Signature REQUIRED For Urgent Requests Only:</b>			
<input type="checkbox"/> <b>Modification Or</b> <input type="checkbox"/> <b>Extension Requests Complete the Section Below:</b>			
Date Last Authorized:		Previous Authorization Number:	
MD/NP/PA justification for modification or extension:			
<b>Patient Information:</b>			
First Name:		Last Name:	
Date of Birth:		Blue Shield of California Promise ID Number:	
Street Address:			
City:		State:	Zip Code:
<b>Referring/Prescribing Provider:</b>			
Name:		Billing Tax ID:	NPI:
Street Address + Suite#:			
City:		State:	Zip Code:
Phone:		Fax:	
Type of Provider: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist		Specialist Type (if applicable):	
Contact Name and Phone Number:			
<b>Servicing/Billing: Provider/Vendor/Lab</b> <i>If same as Referring/Prescribing Provider, Check Here</i> <input type="checkbox"/>			
Name:		Billing Tax ID:	NPI:

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Street Address + Suite#:		
City:	State:	Zip Code:
Phone:	Fax:	
Specialist Type:		
Contact Name and Phone Number:		
<b>If Servicing Provider is billing as part of a Group Contract, enter the Group information below:</b>		
Group Name:	Billing Tax ID:	NPI:
Street Address + Suite#:		
City:	State:	Zip Code:
<b>Billing Facility (If Applicable):</b>		
Facility Name	Billing Tax ID:	NPI:
Street Address + Suite#:		
City:	State:	Zip Code:
Phone:	Fax:	
Contact Name and Phone Number:		
<b>Anticipated Date of Service:</b>		<b>If Lab, Draw Date:</b>
<b>Place of Service: (Check one box only):</b>		
<input type="checkbox"/> Office	<input type="checkbox"/> Group Home	<input type="checkbox"/> On-campus Outpatient Hospital
<input type="checkbox"/> Acute Rehab	<input type="checkbox"/> Home	<input type="checkbox"/> Skilled Nursing Facility
<input type="checkbox"/> Ambulance – Air or Water	<input type="checkbox"/> Hospice	<input type="checkbox"/> Telehealth
<input type="checkbox"/> Ambulance – Land	<input type="checkbox"/> Independent clinic	<input type="checkbox"/> Urgent Care Facility
<input type="checkbox"/> Ambulatory Surgical Center	<input type="checkbox"/> Independent laboratory	<input type="checkbox"/> Other - Please specify:
<input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Inpatient hospital	
<input type="checkbox"/> Birthing Center	<input type="checkbox"/> Intermediate Care Facility	
<input type="checkbox"/> Custodial Care Facility	<input type="checkbox"/> Nursing Facility	
<input type="checkbox"/> End stage Renal Disease Tx	<input type="checkbox"/> Off-campus Outpatient Hospital	
<b>Please enter below all codes requested; unlisted codes must have a description. Include the quantity for each code requested and if applicable, left, right or bilateral designations.</b>		
ICD-10 Codes(s):		
CPT/HCPC Code(s):		
<b>For questions: Call Blue Shield Promise Provider Services at (800) 468-9935</b>		

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**Please include the documentation listed below when you return this form to Blue Shield of California Promise Health Plan:**

- History and physical and/or consultation notes, including:
  - Clinical findings (i.e., pertinent symptoms and duration)
  - Comorbidities
  - Pertinent past procedural and surgical history
  - Past and present diagnostic testing and results
  - Prior conservative treatments, duration, and response
  - Treatment plan (i.e., surgical intervention)
- Radiology report(s) and interpretation (i.e., MRI, CT, PET)
- Laboratory results
- Other pertinent multidisciplinary notes/reports: (i.e., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management), when applicable
- Results/reports of tests performed
- Procedure report(s)