BLUE MEDICARE **ADVANTAGE**

Prior Authorization Request Form

❑ **EXPEDITED REQUEST** – By checking this box, you are stating that applying the standard decision timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Reason for Expedited Request: ______________________________

Return to: Blue Cross and Blue Shield of Kansas City
Attn: Medical Management – Prior Authorization
PO Box 419169
Kansas City, MO 64141

Fax: 877-549-1744

Completion of all fields is required.

MEDICAL RECORDS MUST ACCOMPANY ALL REQUESTS

To be completed for **ALL** requests. Please print clearly. Incomplete or illegible information will delay the review process.

Today's Date: ____________________ Patient Blue KC ID: ____________________

Patient Name: ____________________ Patient Birthdate: ____________________

Requesting Physician Name & NPI: ____________________

Phone Number: ____________________ Fax Number: ____________________

Diagnosis Code: ____________ Diagnosis: ____________________

Procedure Code: ____________ Procedure: ____________________

❑ Inpatient Procedure (services provided may result in admission)
Anticipated Length of Hospital Stay ________

Facility: ____________________ Practitioner: ____________________

Provider Phone Number: ____________________ Provider Fax Number: ____________________

Physician Signature____________________ Date ____________________

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