



BlueCross BlueShield of Texas



Request for Prior Authorization

Medicaid (STAR) and CHIP: 1-877-560-8055

STAR Kids: 1-877-784-6802

Medicaid (STAR) and CHIP Fax: 855-653-8129

STAR Kids Fax: 1-866-644-5456

THIS FORM IS TO BE USED FOR ACUTE CARE SERVICE REQUESTS SUBJECT TO PRIOR AUTHORIZATION AND IS NOT TO BE USED FOR LTSS SERVICE REQUESTS*

Date Request Submitted: _____ Date of Birth: _____ Age: _____
Member Name: _____ Sex: Male Female
Subscriber ID: _____
Address: _____ City: _____
State: _____ ZIP Code: _____ Phone: _____

Requesting Physician Name: _____ NPI: _____
Address: _____ City: _____
State: _____ ZIP Code: _____ Phone: _____

Person completing Form: _____ Phone: _____ Fax: _____
Check One: Medical Surgical Check One: Inpatient Outpatient

Date of Service, if known: _____
Diagnosis: _____ ICD-10: _____
Procedure: _____ CPT/HCPCS: _____
Facility: _____

Service Provider: _____ Tax ID/Medicare ID: _____
Address: _____ City: _____
State: _____ ZIP Code: _____ Phone Number: _____
Provider NPI: _____

In Network: Yes No
History/Treatment Provided by Referring Physician:

Certain request for services require specific clinical information for us to authorize requested services. Always include this information with the Request for Preservice Review form. If there's no form available for the clinical service you are requesting authorization for, please submit clinical information from your own files that would support the request. Thank you.

This authorization is based on medical necessity only and will be contingent upon eligibility and benefits. This is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. Please call the number at the top of this form if this member has any additional medical or behavioral health needs.

*FOR A LIST OF SERVICES REQUIRING PRIOR AUTHORIZATION SEE SERVICES REQUIRING PRIOR AUTHORIZATION @ <http://www.bcbstx.com/provider/medicaid/forms.html>.