



An independent licensee of the Blue Cross and Blue Shield Association

Authorization Request

To submit a Authorization Request (Pre-certification), the Health Care Provider, on the Participants behalf, must notify in **writing** Blue Cross Blue Shield of Wyoming of intent to receive services requiring prior certification. Completion of the prospective request form does not replace a preadmission notification.

For a listing of procedures requiring authorization request (pre-certification), visit www.bcbswy.com/providers. For additional information regarding if a benefit plan requires an authorization request (pre-certification) for service, please contact our Member Services Department at 1.800.442.2376 or 307.634.1393.

If a authorization request (pre-certification) is necessary, **please complete the following form and attach clinical documentation of need for the requested treatment/procedure.**

<p>Requests can be faxed to: Member Services Department 307.432.2917 <i>To help protect your patient's privacy and ensure correct routing, please use a cover sheet.</i></p>	<p>Requests can be mailed to: Member Services Department Blue Cross Blue Shield of Wyoming PO Box 2266 Cheyenne, WY 82003-2266</p>
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INCOMPLETE FORMS OR MISSING CLINICAL DOCUMENTATION WILL DELAY PROCESSING AS THEY WILL NOT BE CONSIDERED UNTIL ALL INFORMATION IS RECEIVED.

Requests marked as **URGENT** must meet the criteria that **failure to receive treatment will result in a life or limb threatening situation.*** Any authorization requests that do not meet the criteria will be treated as non-urgent and may be delayed in processing. BCBSWY does not recognize scheduling conflicts as an urgent request.

Patient Information (please print)

Patient Name: _____
Last Middle First

Benefit Plan #: _____ Date of Birth: _____

Treatment/Procedure Information

Treatment/Procedure Requested: _____

Procedure Code(s)(CPT): _____

Diagnosis Details: _____

Diagnosis Codes (ICD10): _____

Request Begin Date: _____

Medication Required Dosage: _____

Quantity Requested: _____

Physician Information

Rendering Provider: _____

NPI: _____

Provider Phone #: _____ Fax #: _____

Mailing Address: _____
Street City State Zip

Facility Rendering Service

Rendering Facility: _____

NPI: _____

Provider Phone #: _____ Fax #: _____

Mailing Address: _____
Street City State Zip

Completed By: _____ Telephone #: _____
Please Print

*For further explanation of the urgent prospective review criteria, please visit the Department of Labor's website at www.dol.gov.
Confidentiality Notice: This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged and confidential. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message of 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 notify us immediately using 1.800.442.2376 to call us or fax the information you received in error to 307.634.5742. Please destroy or return the original message to us at the above address via the U.S. Postal Service.