



# Prospective Request (Pre-certification)

To submit a Prospective 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 prospective request (pre-certification), visit [www.bcbswy.com/providers](http://www.bcbswy.com/providers). For additional information regarding if a benefit plan requires a prospective request (pre-certification) for service, please contact our Member Services Department at 1.800.442.2376 or 307.634.1393.

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

Requests can be faxed to:  
Member Services Department  
307.634.5742

To help protect your patient's privacy and ensure correct routing, please use a cover sheet.

Requests can be mailed to:  
Member Services Department  
Blue Cross Blue Shield of Wyoming  
PO Box 2266  
Cheyenne, WY 82003-2266

**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 prospective 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: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

Phone Number: \_\_\_\_\_  
Home Work Cell

## Treatment/Procedure Information

Treatment/Procedure Requested: \_\_\_\_\_

Procedure Code(s)(CPT): \_\_\_\_\_

Diagnosis Details: \_\_\_\_\_

Diagnosis Codes (ICD10): \_\_\_\_\_

## Physician/Facility Information

Ordering Provider: \_\_\_\_\_

Ordering Provider Facility: \_\_\_\_\_

Provider Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Provider Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

## Provider/Facility Rendering Service (if different from above)

Rendering Provider: \_\_\_\_\_

Rendering Facility: \_\_\_\_\_

Provider Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Provider Email: \_\_\_\_\_

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](http://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.