WYOMING

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**.

Requests can be faxed to:	**Requests can be mailed to:**
Member Services Department 307.432.2917 *To help protect your patient's privacy and ensure correct routing, please use a cover sheet.*	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* 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.