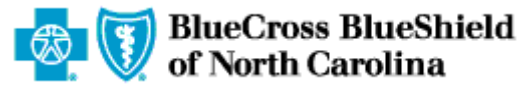


Request for Services (i.e., prior plan approval/prior review and certification/precertification)



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This form is not intended for pharmacy, diagnostic imaging or mental health requests. Please use the appropriate fax form to request prior authorization, quantity limits, or other services.

Submission of this form is solely a notification for request for services and does not guarantee approval. All requests must be reviewed using authorization requirements by the prospective review area/department before authorization is granted.

Requesting Provider Information	Place of Service
Provider Name _____	Name of Facility _____
Provider Number, Tax ID Number, or NPI _____	Attending Service Provider _____
Provider Address _____	Provider Number, Tax ID Number, or NPI _____
City, State & Zip Code _____	Patient Information
Contact Name _____	Patient Name _____
Your Phone Number _____	Patient BCBS ID Number _____
Your Fax Number _____	Patient Date of Birth _____

Primary Diagnosis _____ ICD-9 Code _____

Other Diagnosis _____ ICD-9 Code _____

Inpatient Services

Type of Service	Procedure Code	Date of Admission	Date of Procedure	Date of Discharge
		/ /	/ /	/ /

Home Care

Type of Service	Frequency of Services	Start Date	End Date
		/ /	/ /
		/ /	/ /

DME

Type of DME	HCPCS Code(s)	Start Date	End Date
		/ /	/ /
		/ /	/ /

Outpatient Services

Type of Service	Procedure Code(s)	Date of Service
		/ /
		/ /

Fax this form with required documentation to the appropriate fax number below

Care Management Operations - Commercial Business	800-571-7942		
State PPO	866-225-5258	Federal Employee Program	919-765-2081