CareFirst

The CareFirst BlueCross BlueShield family of health care plans

Precertification Request for Authorization of Services

(For fax requests only)

INSTRUCTIONS: Please complete all fields for a timely response to avoid a delay of authorization. In most cases, you should receive a response via fax or telephone within two business days. Please fax **only** the authorization request form to (410) 781-7661. If requesting an authorization for a CareFirst employee, fax the request to (410) 505-2840. Please submit this completed form only at this time. **Additional clinical information will be requested if needed.**

Request from: Doctor's office Hospital

Please fax authorization request to (410) 781-7661.

Name:	Date:
Telephone Number:	Fax Number:
Participating Provider Number, NPI or Tax ID# (under which you will bill claims):	

Patient's Name:	Date of Birth:	
Patient's Identification Number:	Group Number:	
Address:	Telephone Number:	
City:	State:	Zip Code:

Date(s) of Service or Admit Date(s):	
Place of Service (check one): Inpatient Facility Outpatient Facility Emergency Room Admit Physician's Office	
Admitting/Treating Physician's Name:	Telephone Number:
Physician's Address:	
Diagnosis Code(s) (ICD-10):	
Procedure Code(s) (CPT-4):	
Hospital/Facility:	Telephone Number:
Hospital/Facility Address:	
Hospital/Facility Telephone Number:	
Referral Number (if applicable):	Referral Issue Date:

AUTHORIZATION NUMBER (FOR INTERNAL OFFICE USE ONLY)	
Associate Name:	Completed by:
Date:	Time:
Comments:	

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CUT9233-1E (9/15)