



Submission Instructions:

Please print all information.

IMPORTANT! THIS REQUEST FOR AUTHORIZATION REVIEW **CANNOT** BE PROCESSED WITHOUT SUPPORTING CLINICAL DOCUMENTATION AND/OR INFORMATION – **NO EXCEPTIONS.**

Requests missing clinical information **will be returned** to the requesting provider, **delaying** the review process.

Please fax completed form to the Utilization Management Department:

855.329.8195 (Legacy business for NEPA) or **888.236.6321** (Migrated business for Highmark)

Requesting Physician Information:	Non-Participating Provider Information:
Physician Name:	Specialist Name:
<input type="checkbox"/> Specialist <input type="checkbox"/> PCP	Specialty:
Address:	Address:
Phone #: Fax #:	
Office Contact Person:	Phone #: Fax #:
Member Information:	Non-Participating Facility Information:
Member ID #:	Name:
Member/Patient Name:	Address:
Date of Birth:	
Address:	
Phone #:	Phone #:

Consult Only Evaluate and Treatment # of visits requested: _____

Who is requesting this non-participating request? PCP Specialist Member

Specific Diagnosis/ICD-9 code(s) _____

Specific Procedure/CPT code(s) _____

This service is medically necessary because: _____

Document rationale supporting medical necessity. Attach clinical documentation that supports this request.

Internal use only

Received by IC: _____ Date: _____ Nurse Reviewer: _____

Administrative Denial, Retro Services: _____

Medical Director Decision: Approved: _____ Denied: _____ MD Initials: _____

Authorization Number: _____ Provider notified/Date: _____ Time: _____

Blue Cross of Northeastern Pennsylvania administers health care plans offered by Blue Cross of Northeastern Pennsylvania, Highmark Blue Shield, First Priority Health®, and First Priority Life Insurance Company®.