BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

State of Vermont
Uniform Medical Prior Authorization Form

Urgent Request ☐
Non-Urgent Request ☐

Instructions: Please complete all fields and submit all additional treatment information and/or medical notes that support your request for benefits. If you need more room, you may attach additional pages or forms. Send or fax this information to the member's health plan in advance of the proposed services. Please refer to information provided on the health plans' website for submission instructions and contact information.

Patient/Member Information (* Required Field)

***First Name:** **Middle Initial:** ***Last Name:**		
***Health Insurance ID#:**	***DOB** *(MM/DD/YYYY)*:	***Gender:** Male ☐ Female ☐ Unknown ☐
***Address:** **Apt.#:**		
***City:** ***State:** ***Zip:** **Telephone #:**		

Referring/Requesting Provider Information	**Rendering/Attending Provider Information**
First Name: **Last Name:**	**First Name:** **Last Name:**
NPI/TIN #: **Specialty:**	**NPI/TIN #:** **Specialty:**
Group/Practice Name:	**Group/Practice Name:**
NPI/TIN #:	**NPI/TIN #:**
Address: **Suite #:**	**Address:** **Suite #:**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Office Contact/ Person Completing Form:	
Telephone #:	**FAX #:**

Required Clinical Information (* Required Field)

***Date of Request:**	**Is this request for Out-of-Network services?** Yes ☐ No ☐

***Type of Service Requested**

Inpatient Care: Medical Admit ☐ Mental Health/Substance Abuse Admit ☐ OB ☐ Surgery ☐ Oral Surgery ☐	**Outpatient/Office Care:** Acupuncture ☐ Chiropractic ☐ Infusion/Oncology Drugs ☐ Mental Health/Substance Abuse ☐	**Therapies:** Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐
Testing: Diagnostic Imaging ☐ Diagnostic Medical Test ☐	**Other:** DME ☐ SNF ☐ Home Health ☐ Vision/Glasses ☐ Other ☐ - please specify:	

***Date Diagnosed:**	***Place of Service:** Inpatient ☐ Outpatient ☐ Office ☐ Other ☐ - specify:
***Proposed Date(s) of Service:** From: To:	***Facility Where Service Will be Performed:**
***Proposed Number of Inpatient Treatment Days:**	***Proposed Number of Outpatient Treatment Visits:**
***Primary Diagnosis:**	***Primary Diagnosis Code:**
***Secondary Diagnosis:**	***Secondary Diagnosis Code:**
***Name of Proposed Procedure or Test:**	***CPT/HCPCS or Revenue Code:**
***Requested DME:**	
***DME CPT/HCPCS Code:**	***Requested DME Duration (Date(s) of Service):**
***DME Purchase Price: $**	***DME Monthly Rental Price: $**

Additional Clinical Information Attached: ☐ (No. of pages 0)