BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Precertification Request Form
- Confidential -

Date Submitted: _____

Complete this form to request precertification for a specific procedure/service. If the determination of this review will influence the decision to proceed with treatment, we recommend that you do not schedule treatment until we issue the final decision.

A request for precertification is not necessary for urgent or emergency medical treatment. If a medical review is necessary, please allow up to 15 days for a decision to be made.

Return completed form to: ATTN: Focus Review/Health Care Services
I-20 @ Alpine Road, AX-630
Columbia, SC 29219-0001

You can also fax the completed form to (803) 264-0258 or (803) 264-0181. If you have questions related to eligibility and/or benefits, please contact Provider Services at 1-800-868-2510, Monday through Friday, 8:00 a.m. to 8:00 p.m. (ET).

Member's Name: _____ **Member's ID Number:** _____ **Date of Birth:** _____

☐ Male ☐ Female

Date of Service: _____

Diagnosis (ICD-10-CM Code): _____

Requested Procedure(s) or Equipment:

_____

_____

_____

CPT or HCPCS Codes (required):

_____

_____

_____

Please submit photographs if requesting precertification for one of the following procedures:

- Abdominoplasty (include height and weight) - Blepharoplasty (include visual fields) - Varicose Veins

Note: Do not fax photographs. Mail images to the Focus Review address. All mailed photographs must include the patient's name and policy ID number.

Indicate clinical information to support medical appropriateness (e.g., failed outpatient therapy, laboratory or X-ray results, vital signs), medications, presenting symptoms, plan of treatment, and brief clinical history:

Attach additional supporting documentation (e.g., X-rays, pictures, Certificate of Medical Necessity). ☐ **Attachment(s)** ☐ **No Attachment(s)**

Requestor (If provider, facility, or supplier is out-of-network and requesting in-network benefits, please note and attach the rationale for utilizing out-of-network sources.)**:**

☐ Physician: _____ Tax ID: _____ Phone: _____
Address: _____ NPI: _____ Fax: _____

☐ Facility/Supplier: _____ Tax ID: _____ Phone: _____
Address: _____ NPI: _____ Fax: _____

Note: Although precertification approvals are valid for one year, final reimbursement determinations are based on member eligibility at the time of service, medical necessity criteria, applicable member copayments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements, and BlueCross BlueShield of South Carolina medical policy.

Access BlueCross BlueShield of South Carolina Medical Policies here.