# Prior Authorization Request Form

(Pre-Service Claim)

BlueCross BlueShield Kansas

This form should be used when prior authorization of the services is **required** by Blue Cross and Blue Shield of Kansas. All fields in section 1 are **required**.

CLEAR DATA

## **Section 1** – Provider Information

Provider First Name

Provider Last Name

Provider Address

City

State ZIP Code +4

(_____) _____-_____ Provider Phone Number

(_____) _____-_____ Provider Fax Number

Provider NPI

Provider EIN

Place of Service

Patient First Name

Patient Last Name

_____ /_____ /_____ Patient Date of Birth

Patient ID Number

Patient Group Number

ICD-10 Diagnosis Code(s) - separate with a comma

CPT Codes(s) - separate with a comma

If you want the allowable/contractual obligation for the CPT code(s), please list your charges for each code:

## **Section 2** – Additional Information

Please include history and physical and/or a brief narrative to include: symptoms, previous treatment, and any additional information as is appropriate. Attach additional sheets if necessary.

**Your signature required**

Preparer/Requestor

_____ /_____ /_____ Date Signed

Print Name

## Send this form with all necessary information to:

Blue Cross and Blue Shield of Kansas
Fax: 785-290-0827



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