BlueCross BlueShield of Texas

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

CHIP

Request for Prior Authorization
Phone: 1-855-879-7178
Fax: 1-855-879-7180

Date Request Submitted: _____

Member Name _____ Date of Birth: _____ Age: _____

Certificate Number _____ Sex: ☐ Male ☐ Female

Address: _____ City _____

State: _____ ZIP Code: _____ Phone: _____

Requesting Physician Name: _____ License Number:: _____

Tax ID Number: _____ NPI: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ Phone: _____

Person completing Form: _____ Phone: _____ Fax: _____

Check One: ☐ Medical ☐ Surgical Check One: ☐ Inpatient ☐ Outpatient

Date of Service, if known: _____

Diagnosis: _____ ICD-9: _____

Procedure: _____ CPT/HCPCS: _____

Facility: _____

Service Provider: _____ Tax ID/Medicare ID: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ Phone Number: _____

Provider TPI: _____

In Network: Yes ☐ No ☐

History/Treatment Provided by Referring Physician:

_____

_____

Certain request for services require specific clinical information for us to authorize requested services. Always include this information with the Request for Preservice Review form. If there's no form available for the clinical service you are requesting authorization for, please submit clinical information from your own files that would support the request. Thank you.

Health Plan Use Only

Status

Approved: _____ Expires: _____ Authorization Number: _____

Comments: _____

Representative Name _____ Nurse Reviewer: _____

This authorization is based on medical necessity only and will be contingent upon eligibility and benefits. This is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. Please call the number at the top of this form if this member has any additional medical or behavioral health needs.