PRE-AUTHORIZATION REQUEST FORM

We are in receipt of your request for pre-authorization. Please complete the following form and fax directly to Local 804 at (718) 786-6176.

1. ALL MEDICAL RECORDS FROM EVERY PHYSICIAN THAT HAS TREATED THE PATIENT IN THE PAST AND PRESENT.
2. FULL DETAILS OF COMPLIANCE REPORT OF USE OF CPAP/BIPAP.
3. MEDICAL RECORDS FROM THE PRIMARY CARE PROVIDER TREATING THE PATIENT.
4. ANY LITERATURE AVAILABLE TO SHOW THE MERITS OF THE TREATMENT RECOMMENDED BY THE PHYSICIAN INCLUDING ALL CPT/HCPCS CODES APPLICABLE AND ANY APPROVAL BY THE FDA.

Member's name: _____

Member ID #: _____

Patient's name: _____Date of Birth _____

Provider's name: _____

Address: _____

Tax ID # _____

Phone # _____ Fax #_____

Provider contracted with Blue Cross ___Yes ___No

MED/ SURG REQUESTS: **Date of procedure**_____

ICD Code	CPT code	Description	Charge

MEDICAL EQUIPMENT:

Length of Necessity _____ Rental or Purchase? _____

ICD Code	CPT code	Description	Charge