BlueCross BlueShield Nebraska

Blue Cross and Blue Shield of Nebraska Preauthorization Request Form

If you are a NE provider, please utilize NaviNet ®to submit your request online at: **https://navinet.navimedix.com/**

Date: _____

If you are an out-of-state provider, please fax the completed form, along with all supporting medical records, including lab and radiology-related test results, to fax number: 800-255-2838

You can anticipate a determination on this request within **15** calendar days of receipt of your request. If you indicated this is urgent because it meets urgent care criteria, meaning that the standard time period, 15-day time period could seriously jeopardize the life or health of a patient or subject them to severe pain that cannot be adequately managed without the requested treatment, you can anticipate a determination on the request within **72** hours of receipt of your request. Items marked with " * " are required and must be complete, in order to avoid delays in processing.

You may review criteria determined by BCBSNE Medical Policy at https://medicalpolicy.nebraskablue.com

*We do NOT prioritize based on date of service, please allow for our standard review time (15 days) before scheduling appointments.

☐ Supporting documentation attached ☐ Urgent request Anticipated date of service**: _____

*Member Information	*Ordering/Referring Physician Information
Patient's Name:	Provider's Full Name:
Patient's BCBSNE Member ID:	Provider's Address:
Patient's DOB:	
Patient's Address:	Provider's Specialty:
Patient's Relationship to Subscriber:	Provider's NPI Number:
Subscriber's Name:	
Patient's Phone Number:	

Facility Information (if applicable)	
Facility Name:	Phone Number:
Facility Address:	Fax Number:
	Contact Name:
Facility NPI Number:	Contact Phone:

*Diagnosis and Co-morbidities Description	*Correlating ICD-10 Diagnosis Codes
1.	1.
2.	2.
3.	3.
4.	4.

*Procedure/Service Description	*Correlating CPT/HCPCS Codes
1.	1.
2.	2.
3.	3.
4.	4.

How do you prefer we respond to your Preauthorization Request?

☐ Telephone

☐ Fax

☐ Mail ○ Provider ○ Facility ○ Both

Contact Name:	
Office Name:	
Phone Number:	
Fax Number:	
Address:	