BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

Medicare Advantage Part B Drug Request Form
Clinical Review Request for Blue Cross and Blue Shield of Nebraska
Medicare Advantage Health Plan Members

Attention: – Pharmacy Department
Fax: 1-855-342-9648

Date: _____

Instructions: This form may be used by participating providers to request clinical review of drugs covered under the medical benefit for Blue Cross and Blue Shield of Nebraska Medicare Advantage Health Plan. Complete this form and fax it to 1-855-342-9648 along with supporting clinical documentation. Please contact the intake team at 1-877-399-1671with any questions.

ALL REQUESTED INFORMATION MUST BE PROVIDED FOR CONSIDERATION FOR COVERAGE. PLEASE TYPE OR PRINT CLEARLY

Step 1: Patient and Physician Information

Patient Information		
Name:		
DOB:		
Member ID:		
Ordering Provider Information		
Name:		
Specialty:		
NPI:		
Contact Name & Phone #		
Fax:		
Administering Provider/Facility Information		
Name:		
Specialty:		
NPI:		
Phone:		
Fax:		

Step 2: Provider of Service and Treatment Information

Required for ALL requests Drug Information

Treatment Start Date: _____ Length of treatment:_____

Diagnosis Code(s):_____HCPCS:_____

Drug Name:_____Dose:_____ Frequency: _____

Place of Service (Please Check): ☐ Home ☐ Outpatient ☐ Provider Office

Step 3: Other Relevant History and Information

Please fax all required clinical documentation to 1-855-342-9648