Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

Precertification Request for Medical Injectables

Fax this completed form to 866-494-9927. If the following information is not complete, correct, and/or legible, the review process can be delayed.

General Information		
Date of Request:		
Service Type: ☐ Non-urgent ☐ Urgent/Expedited – Clinical reason for urgency:		
Member Information		
Last Name:	First Name:	
Member ID #:	DOB:	Gender: ☐Male ☐Female
Member Address:		
City, State, and ZIP Code:		
Member Phone:		
Requesting Provider	☐Contracted ☐ Non-contracted	
Last Name:	First Name:	
Provider Specialty:	Provider NPI:	
Tax ID:	Office Phone:	
Office Contact Name:	Office Fax:	
Provider Address:		
City, State, and ZIP Code:		
Servicing Provider	☐Contracted ☐ Non-contracted	
Last Name:	First Name:	
Provider Specialty:	Provider NPI:	
Tax ID:	Office Phone:	
Office Contact Name:	Office Fax:	
Provider Address:		
City, State, and ZIP Code:		
PLEASE SEND ALL CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION		
Request Type: ☐ Initial Request ☐ Continuation Request	Previous Auth #:	
Diagnosis Code (ICD-10):	Description:	
Place of Service: ☐ MD office ☐ Home ☐ Outpatient Hospital ☐ Other:		
Continuation Only: Has member improved or stabilized while on therapy: ☐ Yes ☐ No		

Medication information

Medication:	**Dose/strength:**	**Directions:**	**Quantity:**	**Special Instructions:**

Pertinent Lab Values:
Additional Information: