BlueCross BlueShield of Oklahoma

Instructions for Submitting REQUESTS FOR RECOMMENDED CLINICAL REVIEW

A Recommended Clinical Review is not required. A Recommended Clinical Review is a voluntary, written request by a member or a provider to determine if a proposed treatment or service is covered under a patient's health benefit plan. Recommended Clinical Review approvals and denials are usually based on our medical policies. Click here to view Blue Cross and Blue Shield of Oklahoma medical policies or here to view Federal Employee Program® medical policies and your FEP® Benefit Brochure criteria. The provider and member will be notified when the decision on a Recommended Clinical Review has been reached.

URGENT Definition is below and if not met the request will be re-classified from urgent to standard priority:

- Waiting could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- Waiting could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological function, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

IMPORTANT RECOMMENDED CLINICAL REVIEW REMINDERS

1. Always confirm eligibility and benefits first.
2. You must also complete any other preservice requirements, such as prior authorization, if applicable and required. (For example, all inpatient admissions require prior authorization.)
3. All applicable fields are required. All information and documents provided must be legible. If all required or necessary information is not provided, this may cause a delay in the Recommended Clinical Review process. (Inquiries received without the member/patient's group number, ID number, and date of birth cannot be completed and may be returned to you to supply this information.) Procedure (CPT)/HCPCS codes for requested services along with ICD10 diagnosis codes must be listed on the form.
4. You MUST submit the Recommended Clinical Review to the Blue Cross and Blue Shield Plan that issues or administers the patient's health benefit plan which may not be the state where you are located.
5. Always place the completed Recommended Clinical Review Request Form on top of other supporting documents. Do not send in duplicate requests as this may delay the process.
6. Per Medical Policy, if photos are required for review, please email the photos to photohandling@bcbsil.com. The body of the email should include the patient's first and last name, Group number, Subscriber ID number and the patient's date of birth.
7. A Recommended Clinical Review decision is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's contract or certificate of coverage applicable on the date services were rendered. Exceptions may apply. Regardless of any benefit determination, the final decision to proceed with any treatment or service is between the patient and the health care provider.
8. ONLY use this form for requests for Recommended Clinical Review. Do Not Use This Form To: 1) submit a claim for payment or request payment on a claim; 2) request an appeal; 3) confirm eligibility; 4) verify coverage; 5) request a guarantee of payment; 6) ask whether a service requires prior authorization; 7) request a referral to an out of network physician, facility or other health care provider.
9. Submission of documents as part of the Recommended Clinical Review process does not preclude the Blue Cross and Blue Shield Plan from seeking additional information or documents in relation to its review of other requests or matters.
10. Fax each completed Recommended Clinical Review Request Form to 800-852-1360. If unable to fax, you may mail your request to Blue Cross and Blue Shield of Oklahoma, PO Box 655924, Dallas, TX 75265-5924. For Behavioral Health requests fax to 877-361-7660.
11. For Federal Employee Program members, fax each completed Recommended Clinical Review Request Form to 888-368-3406. If unable to fax, you may mail your request to Blue Cross and Blue Shield of Oklahoma, PO Box 655924, Dallas, TX 75265-5924. **Urgent** and/or **Expedited Appeal** requests should be faxed to 972-766-9776.

BlueCross BlueShield of Oklahoma

FOR INTERNAL USE ONLY
RCR / PRED
(Work Item Type)

Recommended Clinical Review Request Form – Medical and Surgical

It is important to read all instructions before completing this form. This form cannot be used for verification of benefits or to request an appeal of non-certification determination. In submitting your request, you attest that provision of the services requested for review would not violate any federal, state and local laws.
URGENT Definition is below and if not met the request will be re-classified from urgent to standard priority:

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- Waiting could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological function, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

You will receive written notification once a determination has been made.

Standard ☐	Urgent ☐

Today's Date: / /	Scheduled/Anticipated Service/Admission Date: / /

PROVIDER DATA

Submitter Information			
Submitting Provider:			
Contact First Name:		Contact Last Name:	
Telephone Number:			
Ordering Physician			
Ordering Physician: (Individual – Type 1 NPI)			
Ordering Physician First Name:		Ordering Physician Last Name:	
Rendering Physician Provider Specialty:			
Contact First Name:		Contact Last Name:	
Telephone Number:		Fax Number:	
Street Address:			
City:		State:	Zip:
Rendering Provider/Facility			
Rendering Facility/Physician/Provider: (Organization–Type 2 NPI) (Must be 10 digits)			
Rendering Provider/Facility Name:		Tax ID:	
Contact First Name:		Contact Last Name:	
Telephone Number:		Fax Number:	
Street Address:			
City:		State:	Zip:

MEMBER DATA

Member Identification Number: (Include the 3-digit prefix)			
Group Number:		Patient's Date of Birth: / /	
Member's First Name:		Member's Last Name:	
Patient's First Name:		Patient's Last Name:	

DOCUMENTATION:

Attach any documentation that supports or facilitates your review. The following information is required for review. Check all that apply.

Place of Treatment:	Provider Office ☐	Outpatient Facility ☐	Inpatient Facility ☐	Home ☐	Other ☐
Evaluation/Health History ☐	Office/Therapy Notes ☐	Diagnosis Codes:			
Drug Name(s):	Dose/Frequency/Duration:				
Procedure Code(s)/Units:	Left ☐	Right ☐	Bilateral ☐	N/A ☐	
Additional Procedure Code(s)/Units:					
I accept the number of units/days the clinical team determines is medically necessary and appropriate based on clinical submitted. ☐ Yes ☐ No					