If you are a Nebraska provider, please utilize NaviNet® to submit your request online at: **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: 1-866-422-5120

Prior Authorization Priority:

☐ **Standard Requests - Fax: 1-866-422-5120**

You can anticipate a determination on this request within 14 calendar days of receipt of your request.

☐ **Expedited Requests - Fax: 1-866-422-5120**

Provider certifies that applying the standard review time frame may seriously jeopardize the member's life, health, or ability to recover, or result in serious impairment or permanent disability. Request sent as expedited that do not meet the above criteria will be changed to a standard request.

Inpatient and lower levels of care Precertification fax number: 1-866-659-0165

You may review criteria determined by Blue Cross and Blue Shield of Nebraska's (BCBSNE's) Medical Policy at MedicalPolicy.NebraskaBlue.com

*Required information and must be complete in order to avoid delays in processing.

**We do NOT prioritize based on date of service, please allow for our standard review time (14 days) before scheduling appointments.

☐ Supporting documentation attached

Anticipated date of service**: _____

*Member Information	*Ordering/Referring Physician Information
Patient's Name:	Provider's Full Name:
Medicare Advantage 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	Contact Name:
	Office Name:
☐ Fax	Phone Number:
	Fax Number:
☐ Mail ○ Provider ○ Facility ○ Both	Address: