Blue Cross Blue Shield of Rhode Island
500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 bcbsri.com

Inpatient/Outpatient Authorization Form (Non-Portal Users)

General Statement: Providers should verify if the code requested requires prior authorization via BCBSRI.com or by calling the Provider Service Center at 401-274-4848 or 1-800-230-9050.

Please utilize the following form for the following requests. Once completed please, fax the completed form along with clinical information to Utilization Management at 401-272-8885

This form is for the following:

- Out-of-state provider requesting Outpatient/Inpatient services.
- Member eligibility issue (with approved Contact Center Salesforce number)
  Case number provided by the Provider Call Center for approved exceptions: _____

Member Name:	**Member DOB:**
Member ID:	
Requesting Provider Name:	**Requesting NPI:**
Requesting Provider Address	**Office Contact Name:**
Requesting Provider City and State:	**Office Contact Phone Number:**
Requesting Provider Main phone #:	**Contact Fax Number:**
Procedure CPT codes:	**Diagnosis Code:**
Date of service Date:	

Select and complete all fields below:

☐ **Outpatient Procedure** ☐ **Inpatient Request (if applicable)**

Servicing Provider Name:	**Servicing NPI:**
Servicing Provider Address	**Office Contact Name:**
Servicing Provider City and State:	**Office Contact Phone Number:**
Servicing Provider Main phone #:	**Contact Fax Number:**

Is Servicing provider participating with his local plan: ☐ **Yes** ☐ **No**

Please NOTE: This form should not be used for the following services: Any outpatient authorization request that administered by a vendor. Example: High end radiology and cardiology services, behavioral health services, pharmacy benefit management (PBM) drugs, and Fully insured Infertility services.

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Facility Provider Name:	**Facility NPI:**
Facility Provider Address	**Facility Contact Name:**
Facility Provider City and State:	**Facility Phone Number:**
Facility Provider Main phone #:	**Facility Fax Number:**
UR/Case Management Phone	**UR/Case Management Fax**
Date of Inpatient Surgery Date:	**Diagnosis Code:**

Clinical Notes: Clinical documentation must support the medical necessity for the procedure requested. Please attach with this request and indicate any treatments already performed for this diagnosis. Clinical notes are **mandatory** for review for all requests.

Additional Information:

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