Foundation Authorization Request for COLONOSCOPY

Fax Completed Form to 707-442-2047 or Mail to the Foundation, P.O. Box 1395, Eureka, CA 95502

Incomplete request forms will be returned without being processed.

Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

Foundation Authorization Tracking Number:

MEMBER INFORMATION

Patient Name:_____ Gender: M / F Date of Birth:_____

Patient's Address _____ ( ) _____

Street City Zip Phone

Health Plan: HMO: Anthem Blue Cross CaliforniaCare HMO/POS - Blue Shield Cal PERS HMO

PPO: Blue Lake Rancheria - Trinidad Rancheria

Subscriber Name: _____ Group #:_____

Member's Primary Care Provider:_____ Subscriber #:_____

REQUESTING PROVIDER INFORMATION	PROPOSED PROVIDER & FACILITY INFORMATION
Name:	Name:
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone: Fax:	Phone: Fax:
Contact Name:	Tax ID # (Out of Area Providers only):
Today's Date:	Place of Service:

REQUEST FOR COLONOSCOPY – MEDICAL NECESSITY

☐ ROUTINE ☐ URGENT ☐ RETRO Date performed:	CPT:	ICD-9:

Is this colonoscopy request for ☐ SREENING ☐ DIAGNOSTIC ☐ THERAPEUTIC purposes?

Is this an initial exam? ☐YES

☐ NO: Date of last Exam: _____ *Please attach report of previous colonoscopy/pathology with this request.*

Does the patient have any of the following:
Check ALL that apply

Personal history of
- ☐ Colorectal cancer
- ☐ Adenomatous Polyps
- ☐ FAP (familial adenomatous polyposis)
- ☐ Lynch Syndrome (HNPCC)
- ☐ Inflammatory Bowel Disease & related conditions
- ☐ Unexplained GI tract bleeding
- ☐ Unexplained iron deficiency anemia

Family history of
- ☐ Colorectal cancer
- ☐ Adenomatous Polyps
- ☐ FAP (familial adenomatous polyposis)
- ☐ Lynch Syndrome (HNPCC)

Please LIST relative (i.e. parent, sibling, child) and age they were diagnosed: _____

_____

☐ OTHER *NOTES REQUIRED; attach assessment, treatment and other diagnostic procedures that have been performed with this authorization request.* _____

_____

_____

- Approved authorizations are effective from the date they are received and expire three (3) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed. Providers must verify member eligibility within 5 days of the date of service to ensure coverage.
- Claims for services rendered without required prior authorization may be denied reimbursement. Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services.
- The requesting physician or the member may submit authorization appeals to the Foundation Medical Management Department.
- This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety Code §1370, and California Evidence Code §1157.

CONFIDENTIAL INFORMATION

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