CalPERS PPO Hospital Outpatient Facility Request Form

Fax form to (844) 807-8997 or mail form to address at the bottom of page 2. For assistance completing the form, call (800) 541-6652 and select "Authorizations" at the prompt. NPI is required. This form is submitted by providers for PPO members living in California to request approval for elective procedures to be performed at a hospital outpatient facility instead of an ambulatory surgery center due to 1. patient safety, 2. distance to an in-network, free-standing ambulatory surgery center (ASC), or 3. other.

Important instructions

- **Form to be completed and signed by physician for PPO members living in California (benefit maximums do not apply for out-of-state members)**
- Fill in all items completely. All fields are required.
- Print or type your responses in the spaces below.
- Submit form at least **five business days** prior to services being rendered.
- Patient safety and distance requirements described below.
- **Errors or incomplete clinical details on this form may result in your exception request being delayed or denied.**

Section 1 (please mark the surgery being requested)

- ☐ Arthroscopy
- ☐ Cataract surgery
- ☐ Colonoscopy
- ☐ Esophagoscopy
- ☐ Hernia inguinal repair (age 5+, non-laparoscopic)
- ☐ Hysteroscopy uterine tissue sample (with biopsy, with or without D&C)
- ☐ Laparoscopic gallbladder removal
- ☐ Lithotripsy – Fragmenting of kidney stones
- ☐ Nasal/Sinus – Corrective surgery – Septoplasty
- ☐ Nasal/Sinus – Submucous resection inferior turbinate
- ☐ Repair of laparoscopic inguinal hernia
- ☐ Sigmoidoscopy
- ☐ Tonsillectomy and/or adenoidectomy, under age 12
- ☐ Upper GI endoscopy
- ☐ Upper GI endoscopy with biopsy

Referring provider information

Referring/prescribing physician's name	☐ PCP ☐ Specialist	Tax ID number NPI

Servicing provider information

Servicing provider/facility name		
Servicing facility street, city, ZIP code		Tax ID number NPI
Servicing office contact name	Phone	Fax

Member information

First name	Last name	
Member ID number	Date of birth	Gender ☐ Male ☐ Nonbinary ☐ Female ☐ Other
Street address		
City	State	ZIP code

Please enter procedure codes requested

Please enter all codes requested; "By report" codes must have a description of why the code is being used.

ICD-10 code(s)

CPT code(s)

Member criteria (please select one and provide requested information)

Please select criteria which member meets to have service(s) performed at a hospital outpatient facility.

Required documentation includes
History and physical and/or consultation notes.

- Clinical findings (i.e., pertinent symptoms and duration)
- Comorbidities
- Consultation, medical clearance reports, sleep studies, when applicable

Criteria 1: Patient safety – Supporting clinical documentation, below, must be submitted with request.
☐ Comorbid condition(s) (specific comorbid condition(s) must be listed).

☐ If patient requires anesthesia or deep sedation, please explain why.

☐ Other extenuating circumstances (please explain).

Criteria 2: ☐ Distance to an in-network, free-standing ASC is greater than 30 miles from member's address on file.

Criteria 3: ☐ Other (e.g., local ASC does not have necessary equipment, etc.) **Please note: lack of privileges at the local ASC does not qualify as a valid reason for exemption.**

For questions: Call Blue Shield Medical Care Solutions at (800) 541-6652 and select "Authorizations". NPI number is required.

Physician signature

By signing, I certify the information on this form to be factual for this member; due to concerns for the patient's safety, it is unsafe to have the selected procedure performed in a free standing ambulatory surgical center; or, that the closest in-network ASC is greater than 30 miles from the member's home address; or, due to other concerns explained above.

Physician signature | Date

Physician's typed or printed name

Fax: **(844) 807-8997**

Mail: **P.O. Box 629005**
El Dorado Hills, CA 95762-9005