

Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage HMO Non-Delegated ModelSM Prior Authorization Summary

PRIOR AUTHORIZATION REQUIREMENTS THROUGH BLUE CROSS AND BLUE SHIELD OF ILLINOIS (BCBSIL)	
Reminder: Eligibility and benefits as well as prior authorization verification and submissions can be initiated online through the Availity® Essentials Provider Portal .	
Covered Service	Prior authorization required?
Advanced Imaging (PET, MRA, MRI, and CT scans)	Refer to the procedure code list for prior authorization requirements.
Allergy Care (including tests and serum)	Refer to the procedure code list for prior authorization requirements.
Ambulance (Ground and Air)	Ground – No Air – Yes, fixed wing medical transportation
Bariatric Surgery	Yes
Blepharoplasty	Yes
Botox Injections	Yes
Chemotherapy and Radiation Therapy	Yes
Home Health Care and Intravenous Services	Refer to the procedure code list for prior authorization requirements.
Hospital Services (Inpatient, Outpatient)	Refer to the procedure code list for prior authorization requirements.
Injections	Refer to the procedure code list for prior authorization requirements.
Implantable Devices	Yes
Intersex Reassignment Surgery (55970, 55980)	Yes
Laboratory, X-ray, EKGs, Medical Imaging Services and Other Diagnostic Tests	Refer to the procedure code list for prior authorization requirements.
Minor Surgeries	Refer to the procedure code list for prior authorization requirements.
Network Exceptions [including out-of-plan or out-of-network (due to network inadequacy) for managed programs]	Refer to the procedure code list for prior authorization requirements.
Nutritional Counseling Services	Refer to the procedure code list for prior authorization requirements.
Nutritional Products and Special Medical Foods	Yes

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PRIOR AUTHORIZATION PRIOR AUTHORIZATION REQUIREMENTS THROUGH BCBSIL (continued)	
Covered Service	Prior authorization required?
Office Visits to Primary Care Physicians (PCPs) or Specialists (including dietitians, nurse practitioners and physician assistants)	No
Personal Care Services and Private Duty Nursing (home- or school-based) for children under age 21, who qualify under the EPSDT program	Yes
Podiatry (Foot and Ankle) Services	Yes
Routine Physicals	No
Second Opinions (in-network)	No
Skilled Nursing Facility Services	Yes
Special Rehabilitation Services (such as: physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary rehabilitation)	Refer to the procedure code list for prior authorization requirements.
Surgery (including pre-and post-operative care, assistant surgeon, anesthesiologist, organ transplants)	Refer to the procedure code list for prior authorization requirements. (Note: All transplants and pre-transplant evaluations require prior authorization.)
Behavioral Health	
All Inpatient Stays (Facilities/Hospitals)	Yes
All Network Exceptions	Yes
Partial Hospitalization	Yes
Psychological/Neuropsychological Testing	No
Electroconvulsive Therapy	No
Transcranial Magnetic Stimulation	No
Outpatient Services	Refer to the procedure code list for prior authorization requirements.

Checking eligibility and/or benefit information and/or obtaining prior authorization for a service 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 certificate of coverage applicable on the date services were rendered. If you have questions, contact the appropriate number on the member's ID card.

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