

# OB Risk Authorization Form

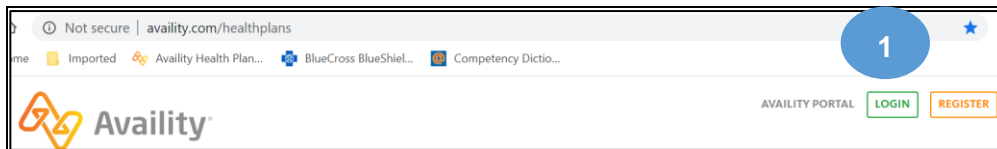
## Quick Reference Guide

### eBusiness Marketing Consultant Contact Information:

East Tennessee Marketing Consultant	Middle Tennessee Marketing Consultant	West Tennessee Marketing Consultant
<p style="text-align: center;"><b>Faith Daniel</b>            (423) 535-6796  <a href="mailto:Faith_Daniel@bcbst.com">Faith_Daniel@bcbst.com</a></p>	<p style="text-align: center;"><b>Faye Mangold</b>            (423) 535-2750  <a href="mailto:Faye_Mangold@bcbst.com">Faye_Mangold@bcbst.com</a></p>	<p style="text-align: center;"><b>Vivian Williams</b>            (901) 544-2622  <a href="mailto:Vivian_Williams@bcbst.com">Vivian_Williams@bcbst.com</a></p>

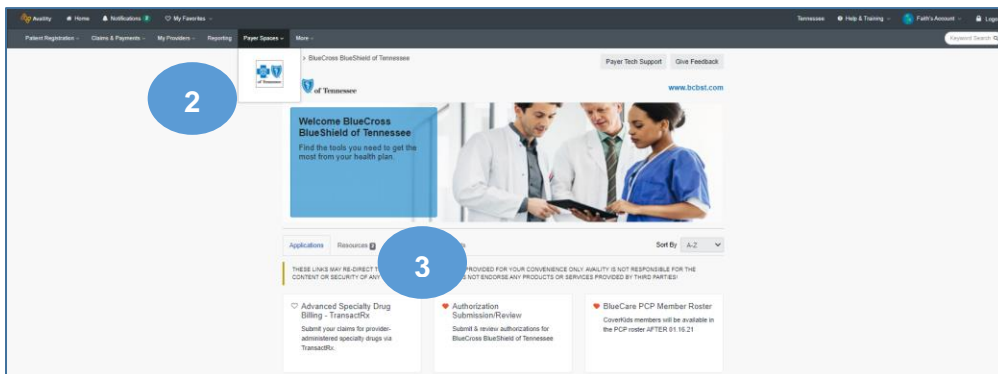
### Getting Started:

**Step 1:** Login to **Availity**® ([www.Availity.com](http://www.Availity.com)) with User ID and password.



**Step 2:** Click on **Payer Spaces** and select the **BlueCross BlueShield of Tennessee**® logo.

**Step 3:** Select **Authorization Submission/Review**.



**Step 4:** Select the **Organization** and **Provider** and then click “Submit.”

Home > BlueCross BlueShield of Tennessee > Authorization Submission/Review

### Authorization Submission/Review

Select an Organization  
Organization Name

Select a Provider  
Provider Name

Cancel Submit

**Step 5:** Click **Authorization / Advance Determination Submission** from drop-down menu.

**Step 6:** Next, select **OB Risk Assessment**.

**Step 7:** Enter Member ID (Patient ID) and click “Search” – the patient information will display on the left side of the screen.

**Step 8:** Click “Continue.”

Home > BlueCross BlueShield of Tennessee > OB Risk Assessment

### OB Risk Assessment

OB Risk Assessment is the notification for obstetrical services that cover the payment for the prenatal care, the delivery, and post-partum care related to pregnancy. An OB Risk assessment can only be authorized if the same physician is providing all care. The OB Practitioner or Primary Care Practitioner (PCP), providing the prenatal, delivery and post-partum care, must contact BlueCross Tennessee at the Member's first appointment to initiate the OB Risk assessment services. All Services provided by an out-of-network provider requires prior authorization.

This is OB Risk Assessment Notification/Authorization/Advance Determination for:

Name:	Christy Hall
Member ID:	W12345678
Group ID:	12345
Birth Date:	11/02/1980
Age:	28
Address:	1 Cameron Hill Circle Chattanooga, TN 37402
Phone:	(423) 555-5555
Eligible:	Yes

Coverage as of Date:

To Select a Patient, Search by ID Number:

Patient ID:

VSHIP can no longer accept newborn requests using e-Health Services for authorization under the mother's subscriber id. If you do not have a unique subscriber id for the newborn and attempt to submit the newborn's subscriber id using e-Health Services, the payment of your claim will be affected. Please contact Utilization Management for BlueCare at 888-423-0131, for TennCare Select at 800-711-4104 or for CareSource at 800-711-4104 to submit newborn requests telephonically.


Cancel Continue

## Step 9: Complete form and click "Continue."

### Submit OB Risk Assessment

#### Enter the Requested Services

**Patient Information**  
Patient ID: M12345678  
Patient Name: Christy Hall

**Requesting/Servicing Provider**  
Provider ID: 4234234 

Name: Harry Potter, MD  
Address: 1 Cameron Hill Circle  
Chattanooga TN 37402  
Phone: (423) 555-5555  
Fax:  
Network Status: In-Network


**Service Information**  
Date of First Office Visit: 01/12/2021  
Estimated Date of Delivery: 08/17/2021  
Last menstrual period: 11/01/2020  
Gravida: 2  
Para: 2  
Did member receive prenatal care in the first trimester?:  Yes  No

**Provider Reason for Referral. (Check all that apply)**

Obstetrical H=History C=Current	Medical	Psychosocial	
<input type="checkbox"/> Preterm labor/delivery <input type="checkbox"/> Multiple gestation <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Pregnancy Induced Hypertension <input type="checkbox"/> Cx or Placental Abnormalities <input checked="" type="checkbox"/> Prior C Section Delivery <input type="checkbox"/> Inadequate weight gain / IUGR <input type="checkbox"/> 17P/Makena Candidate <input type="checkbox"/> Prior NAS Delivery	<input type="radio"/> H <input type="radio"/> C <input type="radio"/> H <input type="radio"/> C <input type="radio"/> H <input type="radio"/> C <input type="radio"/> H <input type="radio"/> C <input type="radio"/> H <input type="radio"/> C <input checked="" type="radio"/> H <input type="radio"/> C <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Anemia ... <input type="checkbox"/> HIV+ / AIDS <input type="checkbox"/> Asthma / respiratory condition <input type="checkbox"/> Cardiac condition <input type="checkbox"/> Sickle cell / clotting disorder <input type="checkbox"/> Hepatitis <input type="checkbox"/> STD (specify) <input type="checkbox"/> Periodontal disease	<input type="checkbox"/> Tobacco/Alcohol use <input type="checkbox"/> Tobacco Cessation RX or referral <input type="checkbox"/> Substance abuse: Prescription opiates, street drugs, bath salts, incense, <input type="checkbox"/> Current Methadone / Buprenorphine TX <input type="checkbox"/> Closely spaced pregnancy (IP1<18 months) <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Homeless / Unstable Housing <input checked="" type="checkbox"/> Anxiety / Depression / BH Disorder <input type="checkbox"/> Other Obstetrical/Medical/Social Determinant

Concerns:

**Diagnosis Code(s)**

ICD Code (No Decimals)	Description
Primary Diagnosis: 009511 	<input type="text"/>

[+Add more codes...](#)

**Notes/Contact Information**  
Contact Name: Test  
Provider Phone: 4235355555 Extension:

[Reset](#) [Back](#) [Cancel](#) [Continue](#)

**9**

The summary page displays:

**Step 10:** Click “Continue.”

Submit OB Risk Assessment Print

Review the OB Risk Assessment Summary

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**Patient Information**

Patient Name :		Address :	C/O BRANDY MATTHEWS1 CAMERON HILL CIRCLE Chattanooga TN 37402
Patient ID :	MBCTEST00	Phone No :	(423)555-5555
Date of Birth :	08/06/1959		

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**Requesting/Service Provider**

Provider Name :	Dr. Harry Potter	Provider Address :	Na Chattanooga TN 37402
Provider ID :	1234567	Phone No :	
Network Status :	In Network	Fax :	

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**Confinement/Service Information**

Date of First Office Visit :	12/01/2020		
Estimated Date of Delivery :	08/01/2021	Last menstrual period :	10/01/2020
Gravida :	3	Para :	2
Did member receive prenatal care in the first trimester?	N		

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**Provider Reason for Referral**

Preterm Labor/Delivery	- History
Prior C Section Delivery	- History
Diabetes Mellitus	
Anxiety / Depression / BH Disorder	

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**Diagnosis Code(s)**

Primary :	O09511 Supervision of elderly primigravida, first trimester
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**Notes/Contact Information**

Contact Name :	Test
Provider Phone :	(423)535-5555
Contact Fax :	(423)435-4355
Member Phone :	(423)535-5555
Notes :	

**10**

Back Cancel Continue

## Authorization Confirmation Page

The confirmation page provides the Authorization status and the Authorization case number. In the example below, the Authorization case number is 401010101.

OB Risk Assessment Confirmation Print

Your submission has been accepted and approved. Your case number for this submission is **401010101**. An authorization is not a confirmation of coverage or benefits. Available benefits remain subject to all contract terms, benefit limitations, conditions, exclusions, and the patient's eligibility at the time services are rendered.

Review & print for your records.

Please [click here](#) to start a new authorization. Do not use the back button.

**Patient Information**

Patient Name	: Christy Hall	Address	: C/O BRANDY MATTHEWS1 CAMERON HILL CIRCLE Chattanooga TN 37402
Patient ID	: M1234567	Phone No	: (423)555-5555
Date of Birth	: 08/06/1959		

**Requesting/Serviceing Provider**

Na

## Auth Inquiry /Clinical Update

You may view an existing Authorization as well as update the request.

**Step 1:** Click **Auth Inquiry/Clinical Update** from the Prior Authorization tool.

**Step 2:** Select **BCBST** and enter search criteria (If you know the auth number, enter and click "search." If you don't have the auth number, you can search by the member).

**Step 3:** Click "Search."

The screenshot shows the 'Authorizations' search page. On the left is a navigation menu with the following items: Home, Authorization / Advance Determination Submission..., Auth Inquiry/Clinical Update, BCBST, Specialty Pharmacy, MSK, HTI, NIA - MAGELLAN, Genetic Testing Submission/Inquiry, and Oncology/Radiology Submission/Inquiry. A blue circle with the number '1' is placed over the 'Auth Inquiry/Clinical Update' menu item. The main content area is titled 'Authorizations' and has a 'Help' link in the top right. It is divided into two search sections. The left section is 'Find Authorizations by Provider, Member and Date Range' and contains fields for 'Provider\*' (a dropdown menu with 'Select' chosen), 'Member\*' (a text input field), and 'From Date \* - To Date' (two date input fields with '10/13/2020' and '04/13/2021' respectively). There are 'Reset' and 'Search' buttons below these fields. A blue circle with the number '2' is placed over the 'BCBST' menu item and the 'Search' button. The right section is 'Find Authorizations by Case/Confirmation number' and contains a 'Confirmation number \*' field with '401010101' entered. There are 'Reset' and 'Search' buttons below this field. A blue circle with the number '3' is placed over the 'Search' button.

Here's an example of the search results:

**Step 4:** Click the **Case ID** link to view the authorization details.

Outpatient

Show  entries Search:

Patient Name	Patient ID	Case ID	From - To Date	Service Description	Status	Requesting Provider	Servicing Provider
Christy Hall	MBCTEST00	<a href="#">401010101</a>	12/01/2020 - 10/01/2021	Routine OB care incl antepartum, Vaginal del & P/P care --- B/Care Req Cat II Code(s)	Fully Approved	BLUECARD PPO PAR PROF	BLUECARD PPO PAR PROF

Showing 1 to 1 of 1 entries Previous **1** Next

The Authorization details display. You may also submit a Clinical Update at the bottom of the form as shown on the following page.

**Outpatient Details** Print

**Outpatient Stay Information**

**Patient Information**

Patient: Christy Hall  
 Member ID: MBCTEST00  
 Group: TennCare/BlueCare

**Authorization**

Authorization ID: 401010101  
 Authorization Status: Fully Approved

**Case Details**

Service Dates: 12/01/2020 - 10/01/2021

**Admitting Facility and Provider**

**Admitting Facility**

Name: BLUECARD PPO PAR PROF  
 ID: 3032125  
 Address: na  
 City: Chattanooga  
 State: TN  
 Zipcode: 37402  
 Country: USA

**Requesting/Servicing Provider**

Name: BLUECARD PPO PAR PROF  
 ID: 3032125  
 Address: na  
 City: Chattanooga

**Services**

Service	Type of Care	Place Of Service	Services By
	Elective	Office	BLUECARD PPO PAR PROF

Diagnosis Code(s)	Description
O09.511	Supervision of elderly primigravida, first trimester

Procedure Code	Service Dates	Description	Requested Days/Hours	Status
59400	12/01/2020 - 10/01/2021	Routine OB care incl antepartum, Vaginal del & P/P care --- B/Care Req Cat II Code(s)	9999	Approved

## Step 5: Submit notes.

An authorization is not a confirmation of coverage or benefits. Available benefits remain subject to all contract terms, benefit limitations, conditions, exclusions, and the patient's eligibility at the time services are rendered.

**Please do not use this form for appeal and reconsideration status checks. Contact Customer Service to check the status.**

**Commercial: 1-800-924-7141**

**BlueCare Plus: 1-800-924-7141**

**Medicare Advantage: 1-800-924-7141**

**BlueCare: 800-468-9698**

**TennCare Select: 800-276-1978**

### Clinical Update Information

Please include all clinical information supportive of the request. LIST ALL PERTINENT INFORMATION SUCH AS: current medical status, activity, diet, medications with dosages, pain scale, physician orders, physician treatment plan, applicable office and/or inpatient progress notes, inpatient and/or outpatient treatment(s) including any special treatments such as alternative therapies or treatment, all pertinent lab values, and any other supportive information.

#### Contact Information

Name:\*

Phone:\*

Fax:\*

#### Service Information

Note Type:\*

#### Clinical Notes:\*

Please include all clinical information supportive of the request. LIST ALL PERTINENT INFORMATION SUCH AS: current medical status, activity, diet, medications with dosages, pain scale, physician orders, physician treatment plan, applicable office and/or inpatient progress notes, inpatient and/or outpatient treatment(s) including any special treatments such as alternative therapies or treatment, all pertinent lab values, and any other supportive information.

#### Contact Information

Name:\*

Phone:\*

Fax:\*

#### Service Information

Note Type:\*

#### Clinical Notes:\*

Only PDF, TIFF, and JPEG files that total < 5,000 KB are allowed. Only alphanumeric characters and underscores are allowed in file names. Spaces are not allowed.

No file chosen

5