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**BlueCross BlueShield
of Delaware**

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INPATIENT/PRE CERTIFICATION FAX AUTHORIZATION REQUEST FORM

Fax: **888.334.3352** or **302.421.8749** Phone: **800.572.2872** or **302.421.3333**

Section I REQUESTING PHYSICIAN INFORMATION

Initial Request Re-fax with additional information Urgent request Medical records attached

Date of request:	Name of office contact:
Physician's full name:	Physician's NPI #:
Physician's address:	Specialty (list type):
Physician's telephone: ()	Physician's fax: ()

Section II

Member name:	BCBSD ID #:
Member's address:	Member's phone number: ()
Date of birth:	Planned admission date:
Name of Hospital:	Hospital's main phone number: ()
Hospital's address	
Diagnosis codes:	Length of stay (LOS) requested:
CPT/Procedure Codes:	

Comments:

Section III AUTHORIZATION INFORMATION

This section is to be completed by BCBSD.

Authorization #:

LOS approved: _____

Please note: If this is a request for services that will be performed within the next 24 hours, call BCBSD at 800.572.2872 or 302.421.3333