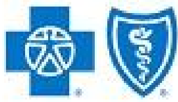

BlueCross BlueShield of Texas

LTSS Authorization Request

Phone: 1-877-301-4394
Fax: 1-866-644-5456

Date Request Submitted:

Member Name:

Address: City

State: ZIP Code: Phone:

Person completing Form: Phone: Fax:

Service Type: ☐ Agency ☐ CDS ☐ SRO

Service	New Request?	Current Service?	
☐ Personal Care Services	☐	☐	Hours/Week:_________
☐ Private Duty Nursing	☐	☐	Hours/Week:_________
☐ PAS/Habilitation	☐	☐	Hours/Week:_________
☐ Day Activity and Health Services (DAHS)	☐	☐	Hours/Week:_________
☐ PPECC	☐	☐	Hours/Week:_________
☐ Respite	☐	☐	Hours/Week:_________
☐ Supported Employment	☐	☐	Hours/Week:_________
☐ Employment Assistance	☐	☐	Hours/Week:_________
☐ Flexible Family Support Service	☐	☐	Hours/Week:_________
☐ ERS	☐	☐	Months: _____
☐ Adaptive Aids	☐	☐	$___________
☐ Minor Home Mods	☐	☐	$___________
☐ Transition Assistance Service	☐	☐	$___________

Date of Service: Begin Date:_________ End Date: __________

Provider NPI/API: _______________ **Agency Name**:____

Justification for Request (Diagnosis Code Required):____

Certain request for services require specific clinical information for us to authorize requested services. Always include this information with the Request for LTSS Authorization Form. If there's no form available for the service you are requesting authorization for, please submit information from your own files that would support the request. Thank you.

Health Plan Use Only

Status

Approved: ____________ Expires: ____________ Authorization Number: ____________

Comments:

Representative Name Nurse Reviewer:

This authorization is based on medical necessity only and will be contingent upon eligibility and benefits. This is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. Please call the number at the top of this form if this member has any additional medical or behavioral health needs.

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