Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Commercial PPO Benefit Enhancement Form

☐ **Initial Request** ☐ **Extension**
Complete this form and fax it to
1-866-411-2573

- Please allow 24-72 hours for processing requests.
- Precertification is not a guarantee of payment.
- Facility and provider must participate with local Blue Cross plan or member may incur higher costs.
- Please verify eligibility and benefits prior to request.

Complete every field unless otherwise noted. Enter N/A if not applicable.
Incomplete or illegible submissions will be returned unprocessed.

Contact information

Contact name		Title & Facility	
Date	Contact phone number	Fax number	E-mail

Patient information

Name		Date of birth	Policy number		
Address		City	Telephone	State	ZIP code
Advance directives ☐ Yes ☐ No If yes, please attach copy					

Benefit Enhancement Request

Medication/Infusion ☐	DME/Supplies ☐	5th Level Hospice ☐	Specialty Visits ☐
Home Health Care ☐	Home Visiting Physician ☐	Ambulance Transfer ☐	Mental Health Counseling ☐
Hyperbaric Chamber ☐	Prosthetics/Orthotics ☐	Other ☐	
Pertinent information for above request:			

Provider demographics

Admission date	Facility name	NPI number	Estimated length of stay (# of days)	
Facility address		City	State	Zip
Participates with local PPO: ☐ Yes ☐ No		Facility phone number	Facility fax number	
Transfer from (facility name)		Other:	Acute hospital admission date	
Current treating physician		Current treating physician phone ( )		
Diagnosis with ICD 10 Code				

Current clinical information

Height	Weight	Blood pressure	Heart rate	Respiratory rate	Temperature	Alert and oriented
Treatments:						Medical condition stabilized ☐ Yes ☐ No
Pertinent medical history:						
Surgeries/procedures 1)						Date
2)						Date
Dialysis: ☐ Yes ☐ No Type: _____ Frequency: _____						

Discharge plans (Must be filled out on initial request)

Discharge date (tentative/actual)	Assistive devices	Resides: ☐ Alone ☐ w/Spouse ☐ w/Other

Name of Support and Phone Number

	Name	Phone Number		Name	Phone Number
☐ Spouse:			☐ Family/friend:		
☐ Children:			☐ Home health care:		
☐ Children:			☐ Other:		

Home description (levels, bed/bath location, steps to enter, etc.)

Discharge to home: ☐ Yes ☐ No

Alternative level of care: ☐ Rehab ☐ Assisted living ☐ Skilled nursing facility ☐ Adult foster home ☐ Long term center ☐ Other: _____

Additional Pertinent Information