



**BlueCross BlueShield
of New Mexico**

New Mexico Uniform Prior Authorization Form Submission Information

[The NM Uniform Prior Authorization Form is available at bcbsnm.com](http://bcbsnm.com)

To Submit the NM Prior Authorization Form for:	Submit to:	Coverage Review:
BCBSNM Commercial/Retail members for Physical Health services	Electronically: Avality Facsimile: 866-589-8253	M-F 8:00am – 5:00pm MST 800-325-8334 After-hours coverage review: 888-349-3706
BCBSNM Commercial/Retail members for Behavioral Health services	Electronically: Avality Facsimile: 877-361-7659 / 312-946-3737	24-Hour coverage review: 888-349-3706
BCBSNM Commercial/Retail members for Pharmacy services	Electronically: CoverMyMeds Facsimile: 877-243-6930	24-Hour coverage review: 800-544-1378
Blue Cross Community CentennialSM members for Physical Health services	Electronically: Avality Facsimile: 505-816-3854	M-F 8:00am – 5:00pm MST 877-232-5518 After-hours coverage review: 877-232-5518
Blue Cross Community CentennialSM members for Behavioral Health Services	Electronically: Avality Facsimile: 505-816-4902	M-F 8:00am – 5:00pm MST 877-232-5518 After-hours coverage review: 877-232-5518
Blue Cross Community CentennialSM members for Pharmacy Services	Electronically: CoverMyMeds Facsimile: 877-243-6930	24-Hour coverage review: 866-689-1523

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To file electronically, send to: [See Cover Sheet](#)

To file via facsimile, send to: [See Cover Sheet](#)

To contact the coverage review team for **BCBSNM Commercial/Retail** plans, please see the [NM Uniform Prior Authorization Cover Sheet](#) on the "Forms" page of bcbsnm.com/provider under the "Education and Reference" tab.

[1] Priority and Frequency

a. **Standard** Services scheduled for this date:

b. **Urgent/Expedited** Provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the enrollee.

c. **Frequency** Initial Extension Previous Authorization #:

[2] Enrollee Information

a. Enrollee name:

b. Enrollee date of birth:

c. Subscriber/Member ID #:

d. Enrollee street address:

e. City:

f. State:

g. Zip code:

[3] Provider Information: Ordering Provider Rendering Provider Both

Please note: processing delays may occur if rendering provider does not have appropriate documentation of medical necessity. Ordering provider may need to initiate prior authorization.

a. Provider name:

b. Provider type/specialty:

c. Administrative contact:

d. NPI #:

e. DEA # if applicable:

f. Clinic/facility name:

g. Clinic/pharmacy/facility street address:

h. City, State, Zip code

i. Phone number and ext.:

j. Facsimile/Email:

[4] Requested medical or behavioral health course of treatment/procedure/device information (skip to Section 8 if drug requested)

a. Service description:

b. Setting/CMS POS Code Outpatient Inpatient Home Office Other*

c. *Please specify if other:

[5] HCPCS/CPT/CDT/ICD-10 CODES

a. Latest ICD-10 Code

b. HCPCS/CPT/CDT Code

c. Medical Reason

a. Latest ICD-10 Code	b. HCPCS/CPT/CDT Code	c. Medical Reason

[6] Frequency/Quantity/Repetition Request

a. Does this service involve multiple treatments? Yes No If "No," skip to Section 7.

b. Type of service:

c. Name of therapy/agency:

d. Units/Volume/Visits requested:

e. Frequency/length of time needed:

[7] Prescription Drug

a. Diagnosis name and code:

b. Patient Height (if required):

c. Patient Weight (if required):

d. Route of administration Oral/SL Topical Injection IV Other*

*Explain if "Other:"

e. Administered: Doctor's office Dialysis Center Home Health/Hospice By patient

