MASSACHUSETTS

CLINICAL CRITERIA REQUEST FORM

Return this form by mail, email, or fax.

Email: ssforms@bcbsma.com
Fax: **1-617-246-3162**

Blue Cross Blue Shield of MA
One Enterprise Drive, Mail Stop 02/06
Quincy, MA 02171

If you are a member or a prospective member and would like to request the clinical criteria we use to make medical necessity determinations for coverage of services, please complete the information below.

Please note: This criteria request form is for criteria requests only. Do not use this form to request coverage of any services or to request authorization for services.

Today's date:	

YOUR INFORMATION

Name:	
Address 1:	
Address 2:	
City, State & Zip Code:	
Fax number:	

Are you currently a member of Blue Cross Blue Shield of Massachusetts? ☐ Yes ☐ No

REQUEST INFORMATION

For what type of services are you requesting clinical criteria? ☐ Medical services
☐ Behavioral health services

For us to send you the appropriate criteria, please list the specific services you are interested in having performed:

HOW DO YOU PREFER TO RECEIVE THE CRITERIA?

☐ US Mail
☐ Email (please enter email address):
☐ Fax

MPC_020722-3P (rev. 02/22)