

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.

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