



# CLINICAL CRITERIA REQUEST FORM

Return this form by mail, email, or fax.

Email: [ssforms@bcbsma.com](mailto:ssforms@bcbsma.com)

Fax: 1-617-246-3162

Blue Cross Blue Shield of MA  
25 Technology Place  
Mail Stop 03/02  
Hingham, MA 02043

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:	
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## 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