Clinical Criteria Request Form

Today's date: ....

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.

Name and address:

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

For what type of services are you requesting clinical criteria?

☐ Medical Services ☐ Behavioral Health Services

In order 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 this information?

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

☐ Fax (please enter fax number): ....

How to submit this form:

US Mail:

Blue Cross Blue Shield of MA

One Enterprise Drive

Mail Stop 0206

Quincy, MA 02171

Email: ssforms@bcbsma.com

Fax: 617-246-3162

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