



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