MASSACHUSETTS

# REQUEST FORM FOR CLINICAL CRITERIA

**Date:**

Complete this form if you'd like to know the clinical criteria we use to make medical necessity determinations for coverage. This form is for clinical criteria requests only, and can't be used to request coverage for services or authorization of services. It may be completed by a member or potential member, or by a doctor or other provider on their behalf.

## Contact Information

| | | |
|---|---|---|
| **Name:** | | |
| **Address 1:** | **Address 2:** | |
| **City:** | **State:** | **ZIP:** |
| **Phone:** | **Email:** | **Fax** (optional)**:** |

**Are you currently a member of Blue Cross Blue Shield of Massachusetts?**

❑ Yes ❑ No

**What type of services are you requesting clinical criteria for?** (Check all that apply.)

❑ Medical Services ❑ Mental Health Services

**List the specific services you're interested in receiving so we can send you the appropriate criteria.**

**How do you prefer to receive this information?** (Check one.)

❑ U.S. Mail ❑ Email ❑ Fax

## How to Submit This Form

**U.S. Mail:**
Blue Cross Blue Shield of MA
One Enterprise Drive
Mail Stop 0206
Quincy, MA 02171

**Email:** ssforms@bcbsma.com

**Fax:** 1-617-246-3162



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