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 ☐ Mental Health ☐ Pharmacy

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
25 Technology Place
Mail Stop 0302
Hingham, MA 02043

Email: ssforms@bcbsma.com

Fax: 1-617-246-3162

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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