



BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization/Predetermination Request for Blepharoplasty and Brow Ptosis Repair

Please **fax** completed forms to **(816)502-4910**
If you have any questions please call (816)395-3989

Patient's Name	Physician's Name	
BCBSKC ID (NOT SS#):	Date of Service	
BCBSKC 8-digit Provider # or NPI#	Facility	
Contact Name	Contact Fax No.	Contact Phone No.

BCBSKC will provide coverage for blepharoplasty and ptosis repair when it is determined to be medically necessary.

ICD-9 Codes _____; CPT or HCPCS Codes: _____

History of condition (including duration of condition, previous failed conservative treatments, etc.): _____

Does the patient have the following complaints:

- _____ Interference with vision or visual field _____ difficulty reading due to upper eyelid drooping
- _____ looking through the eyelashes _____ seeing the upper eyelid skin _____ chronic blepharitis
- _____ Have treatable causes for the ptosis been ruled out

What is the lid margin to centered light reflex distance in mm? _____ left _____ right
 Visual field testing demonstrates a loss of: _____ left _____ right
 Marginal Reflect Distance (MRD): _____ left _____ right

Photographs are required for review.

For BCBSKC Use Only	
BCBSKC Authorization Number: _____	Date Span: _____ to _____
Medical Management Team Member Name: _____	

Please allow two (2) business days from date of receipt of all necessary information for determination.
Duplicate submissions slow the process.

All patient information is strictly confidential.
Incomplete forms will be returned.