BlueCross BlueShield
Federal Employee Program

ACA Bowel Prep Prevention Coverage Member Request Form

Send completed form to:
Service Benefit Plan
Attn: Reconsideration
P.O. Box 52080
Phoenix, AZ 85072-2080
FAX: 1-877-378-4727

CARDHOLDER COMPLETES

Date: ____ / ____ / _____

Patient Name: _____ / _____ / _____
First MI Last

Patient Address: _____
Street Address

_____
City / State / Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ☐ F ☐ R _____

If approved, your $0 prevention benefit override will be applied to one additional claim in the benefit year.

PHYSICIAN COMPLETES

_____ _____ _____
Physician Name (Print Clearly) Specialty Physician NPI #

Physician Address: _____
Street Address

_____ (_____)_____ (_____)_____
City / State / Zip Office Phone Office Fax

NOTE: Drug selection and prescribing physician signature must be completed to process this request:

Please select drug requested:

❑ **Suprep** ❑ **Gavilyte-N** ❑ **Gavilyte-G** ❑ **Gavilyte-C** ❑ **Gavilyte-H** ❑ **TriLyte**

❑ **PEG-Prep** ❑ **PEG-3350** ❑ **PEG-3350/KCL Solution/Sodium** ❑ **PEG-3350 NASUL C**

I attest, as prescribing physician, to ALL of the following:

i. The requested medication is being used for **emptying out the bowel before colonoscopy procedure**
ii. The procedure is being completed to **screen for colon and rectal cancers**

_____ ____ /____ /____
Physician Signature Date

Prescriber Certification: I certify that I am the physician and all information provided on this form to be true and correct to the best of my knowledge and belief. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with Blue Cross and Blue Shield. Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.