<Insert delegate name and/or logo>

NOTICE OF AUTHORIZATION OF SERVICES

<Date>

Member Name:

Member ID:

Plan Name: <Blue Shield TotalDual Plan (HMO D-SNP) H5928-005 **OR** Blue Shield TotalDual Plan (HMO D-SNP) H5928-055 **OR** Blue Shield Inspire (HMO DSNP) H5928-054>

Reference Number:

Requesting Provider:

Dear <Name>,

We have approved coverage for the following service(s) requested by your provider/doctor.

Service request(s):

<Insert service code>	QTY: <Insert Quantity>	<Insert type of service>
<Insert service code>	QTY: <Insert Quantity>	<Insert type of service>

All authorizations are considered on a medical-need basis and your plan's coverage. This approval assumes you have this health plan coverage on the date you are treated.

If you need more visits, treatments, testing or surgery, you may need another authorization. If you don't get an authorization before the service is given, it may mean that no payment or a lower payment will be made based on the terms of your health plan.

If you have any questions or require additional information, please call us at <organization 800 number and hours>.

Thank you for being a member of Blue Shield of California.

Sincerely,

Medical Director,

CC:

Enclosure(s):
"Notice of Non-Discrimination"
"Language Assistance Notice"