



**BlueCross BlueShield
of Oklahoma**

BlueLincs[®] HMO

Allergy Authorization Request
Fax: (918) 551-2211
www.bcbsok.com

Patient's Name _____
Date of Request _____
Date of Service (if known) _____
Diagnosis _____
PCP Name _____
PCP Phone _____
PCP Fax _____
PCP Contact Person _____
Number of visits needed: _____
Allergy testing needed: Yes No

BlueLincs ID# _____
Date of Birth _____
ICD 9 _____
Specialist Name _____
Specialist Phone _____
Specialist Fax _____
Specialist Contact Person _____
CPT Code _____
CPT Code _____

Monthly Medication		
Doses	Number per month _____	CPT Code _____
Treatments		
Units		
Injections		
Number of vials of serum needed per month _____		CPT Code _____
<i>You must bill monthly. BlueLincs will only pay for one month of serum at a time.</i>		
Number of injections per vial _____		
Frequency of injections _____		
Will be administered by: Specialist PCP Other		
Additional CPT Code needed (such as pulmonary function testing) _____		
Comments: _____		

Authorization number given by BlueLincs:
Office visits and testing _____
Serum and injections _____
Authorization valid from _____ until _____

Most benefit plans have a 50 percent copay for allergy serum and the administration of allergy serum. This referral does not guarantee payment for services provided. Payment depends upon member eligibility, benefits and participation in BlueLincs program.