



**BlueCross BlueShield  
of Tennessee**  
An Independent Licensee of the  
BlueCross BlueShield Association

<input type="checkbox"/> <b>TennCare<sup>SM</sup> Select</b> <input type="checkbox"/> <b>BlueCare<sup>â</sup></b>
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**REQUEST FOR PRENATAL VISIT**

<b>To:</b>	<b>From:</b>
Agency: _____	Case Manager: _____
Attention: _____	Telephone No.: _____
FAX No.: _____	FAX No.: _____

**Obstetric Provider**

Practitioner's Name: _____	Provider No.: _____
Telephone No.: _____	FAX No.: _____

**Patient Information**

Member Name: _____	Member ID No.: _____	D/O/B: _____
Member Address: (Street) _____		
(City) _____	(County) _____	(State) _____ (ZIP) _____
Member Telephone No.: _____	Eligibility: _____	

**Authorized Service**

Authorization No.: _____	*Date Requested: _____
<input type="checkbox"/> One Visit <input type="checkbox"/> Two Visits <input type="checkbox"/> One Postpartum Visit	
Other (please explain): _____	
_____	

**Patient Status**

Diagnosis: _____	Diagnosis Code: _____
Trimester: _____	Gravida: _____ Para _____ EDC: _____
Comments: _____	
_____	

\*Visit must be completed within one week of referral date.

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\*\*\*Authorization is not a confirmation of coverage of benefits available. Benefits remain subject to all contract terms, conditions, exclusions, and to the patient's eligibility at the time services are rendered.

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