



TX HB3459 Provider PA Exemption Inquiry Form

This exemption provider inquiry is only to be leveraged for questions specific to a provider's PA exemption status or PA exemption review.

TX HB3459 created a requirement for third-party payers to grant Prior Authorization Exempt status for elective services and/or admissions to various levels of care for providers and facilities that meet high standards.

TXHB3459 applies to:

- TX professionals and facilities with a **minimum of 5 prior authorizations that at least 90% of their prior authorization requests approved** for a particular health care service in the last 6 months

For Additional Information on HB3459 & PA Exemptions, providers can visit <https://www.bcbstx.com/provider/claims/claims-eligibility/um/pa-exemptions-hb3459>.

Inquiry Reason:

Select One:

- No Exemption Received
- Question Re: Exemption Received
- Exemption **Renewal** Review

Describe your Inquiry below:

Is this inquiry related to a Facility or Professional Exemption?

Select One:

- Facility
- Professional

Which Care Category is this inquiry related to?

Select One:

- Physical Health
- Behavioral Health
- Pharmacy/Specialty Review Unit (SRU)



<p>Physical Health Treatment Setting: Elective Inpatient Select Care Category (for Inpatient Acute):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Medical <input type="checkbox"/> Hospice <input type="checkbox"/> Maternity <input type="checkbox"/> Surgical <input type="checkbox"/> Transplant <p>Elective Inpatient Post-Acute Select Care Category (for Post-Acute):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Long Term Acute Care Facility (LTAC) <input type="checkbox"/> Rehab <input type="checkbox"/> Skilled Nursing Facility (SNF) <p>Elective Outpatient Select Care Category (for Outpatient):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Breast Surgery <input type="checkbox"/> Cardiology <input type="checkbox"/> Ear, Nose, Throat (ENT) <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Joint/Spine Surgery <input type="checkbox"/> Molecular Genetic Lab Testing <input type="checkbox"/> Neurology <input type="checkbox"/> Orthognathic Surgery/Oral Surgery <input type="checkbox"/> Orthopedic Musculoskeletal <input type="checkbox"/> Pain Management <input type="checkbox"/> Radiation Therapy/Radiation Oncology <input type="checkbox"/> Sleep Medicine <input type="checkbox"/> Transplant <input type="checkbox"/> Wound Care <input type="checkbox"/> Durable Medical Equipment (DME) <input type="checkbox"/> Home Infusion <input type="checkbox"/> Home Nursing Visit <input type="checkbox"/> Home Hospice <input type="checkbox"/> Private Duty Nursing (PDN) <input type="checkbox"/> PT/OT/ST (Includes Home/Outpatient) <input type="checkbox"/> Air Ambulance Fixed Wing <input type="checkbox"/> Home Hemodialysis 	<p>Behavioral Health Treatment Setting: Elective Inpatient Post-Acute Select Care Category (for Post-Acute):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inpatient Rehab <input type="checkbox"/> Residential Treatment Center <p>Elective Outpatient Select Care Category (for Outpatient):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Electroconvulsive Therapy (ECT) <input type="checkbox"/> Applied Behavior Analysis (ABA) <input type="checkbox"/> Psychological Testing <input type="checkbox"/> Partial Hospitalization Program (PHP) <input type="checkbox"/> Intensive Outpatient Program (IOP) 	<p>Specialty Review Unit (SRU) Treatment Setting: Elective Outpatient Select Care Category (for Outpatient):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Infusion Site of Care <input type="checkbox"/> Medical Oncology & Supportive Care <input type="checkbox"/> Provider Administered Drug Therapy <input type="checkbox"/> Specialty Drugs <p>Detailed Category:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Angiogenesis Inhibitor <input type="checkbox"/> Asthma Agent <input type="checkbox"/> Biologic Response Modifier <input type="checkbox"/> Blood Modifier <input type="checkbox"/> Botulinum agent <input type="checkbox"/> CAR-T therapy <input type="checkbox"/> CNS agent <input type="checkbox"/> Enzyme Replacement <input type="checkbox"/> Gene therapy <input type="checkbox"/> Hereditary Angioedema (HAE) agent <input type="checkbox"/> Hormone Modifier <input type="checkbox"/> Immunoglobulin Replacement <input type="checkbox"/> Oncology Only <input type="checkbox"/> Miscellaneous
---	--	---

Professional or Facility Name:	Network Status: INN or OON
National Provider Identification (NPI) (Individual):	Tax ID Number (TIN):
Attending Professional or Facility Specialty:	



Preferred Communication

How would you like to receive response to your inquiry form from Blue Cross and Blue Shield of Texas?

Select One & Provide Detail

- EMAIL (if different from sender's email address)
- FAX
- MAIL

Enter Email:
Enter Fax:
Enter Mailing Address:
Person Completing Form (Name/Title):

Return completed form to: TX_PA_Exemption_Inquiries@BCBSTX.com.

Professionals can also file a complaint with TDI at <https://www.tdi.texas.gov/consumer/health-complaints.html>.