Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

**Pre-authorization Request Form**
**Skilled nursing (SNF), Long Term Acute Care (LTAC), Inpatient Rehabilitation (IP Rehab)**
**Fax:** 1 (855) 848-8220
**Mail to:** PO Box 1271, WW5-53
Portland, OR 97207-1271

**Instructions:** This form should be completed and filled out by the requesting provider. Prior to completing this form, please confirm the patient's benefits, eligibility and whether pre-authorization is required.

**Expedited request. I attest that this request meets the definition indicated below by checking the expedited request box. ☐ Fax to 1 (855) 240-6498.**

**Expedited is defined as:** When the member or his/her provider believes that waiting for a decision within the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy.

| **SECTION 1 – PATIENT INFORMATION** | | | |
|---|---|---|---|
| Patient Name (Last) | First | MI | Patient's Phone # |
| Patient's Regence Member ID # | Group # | | Date of Birth |

| **SECTION 2 – PROVIDER INFORMATION** | | | | |
|---|---|---|---|---|
| Requesting/Prescribing Provider Name | | Tax ID # | | |
| NPI # | Office Phone # | Confidential Voice Mail ☐ Yes ☐ No | Fax # | |
| Mailing Address | | City | State | ZIP Code |
| Provider Specialty | | Email Address | | |
| **Who should we contact if we require additional information?** | | | | |
| Name | Phone # Ext. | Confidential Voice Mail ☐ Yes ☐ No | Fax # | |
| **If a physician reviewer needs a peer to peer discussion before a determination, please provide the treating provider's direct phone number and availability for the next 3 to 5 days.** | | | | |
| Phone #: Ext: | Date: Time: | Date: Time: | Date: Time: | |
| Facility Name | | Tax ID # | NPI # | |
| Mailing Address | | Fax # | | |
| City | State | ZIP Code | Phone # Ext. | Confidential Voice Mail ☐ Yes ☐ No |
| Email Address | | **Note:** This form does not serve as a notification of admission. Please reference our provider website for instructions about how to notify us of an admission. | | |

## SECTION 3 – PREAUTHORIZATION REQUEST

Date of Admission _____

Transfer from another facility? ☐ Yes ☐ No If Yes, Facility Name: _____

| | |
|---|---|
| Skilled Services Needed: | |
| Level of Function/Cognition: | Current: |
| | Prior: |
| Ambulatory Ability: | |
| Social Support: Lives | ☐ Alone ☐ w/son/daughter ☐ w/ spouse ☐ w/ other _____ |

**Please provide all diagnosis and their descriptions.**

| Diagnosis code(s) and description(s) | |
|---|---|
| Primary: | |
| Second: | |
| Third: | |

## SECTION 4 – DOCUMENTATION SUBMISSION

**Submit the following documentation, as appropriate, with this request:**

Specific clinical information documenting the applicable MCG™, Medicare, or BCBS FEP medical necessity criteria, **including:**

- History and physical
- PT/OT/SLP assessment and current notes within past 48 hours, as applicable
- Current symptoms and functional impairments
- Treatment history and any other information, such as chart notes that support medical necessity for the request.
- Physician Progress Notes from the past 48 hours

Any other supporting documents you would like considered, such as letters from outpatient providers, etc.