



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

Pre-authorization Request Form Behavioral Health

Fax: 1 (888) 496-1540

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.

Is this for a Medicare Preservice Benefit Organization Determination Request? [ ] Yes [ ] No

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
Please check one: [ ] Requesting/Prescribing Provider [ ] Rendering/Treating Provider
Provider Name Tax ID #
NPI # Office Phone # Confidential Voice Mail Fax #
Mailing Address City State ZIP Code
Provider Specialty Email Address

Who should we contact if we require additional information?
Name Phone # Confidential Voice Mail Fax #
Ext. [ ] Yes [ ] No

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 #: Date: Date: Date:
Ext: Time: Time: Time:
Facility Name Tax ID # NPI #
Mailing Address Fax #
City State ZIP Code Phone # Confidential Voice Mail
Ext. [ ] Yes [ ] No
Facility Type: [ ] Freestanding [ ] Acute Email Address

### SECTION 3 – PREAUTHORIZATION REQUEST

Date of Services/Anticipated Admission \_\_\_\_\_

Substance Use Disorders: ASAM Level of Care Requested:  2.0/2.1  2.5  3.5  3.7  4.0

Mental Health Care Requested:

- Inpatient  Residential Treatment  Partial Hospitalization  
 Intensive Outpatient  Other, please specify \_\_\_\_\_

**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.

**Please provide all diagnosis, CPT or HCPCS codes and their descriptions.**

Diagnosis code(s) and description(s)	CPT or HCPCS code(s) and description(s)
Primary:	
Second:	
Third:	

### SECTION 4 – DOCUMENTATION SUBMISSION

**Please submit the following documentation, as appropriate for this request:**

Psychiatric or substance use disorder evaluation or intake assessment including:

- Family history
- Medical, psychiatric and substance use history
- Mental status exam
- Personal and social history (psychosocial)
- History of current complaint/clinical status
- Member's current complaint/clinical status

History and physical/nursing assessment (if available) including:

- Current vitals
- Current medical concerns/risks

Substance use disorders only:

- Clinical Institute Withdrawal Assessment (CIWA) or
- Clinical Opiate Withdrawal Scale (COWS) score or
- Description of active withdrawal symptoms

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