Regence

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

# Pre-Authorization Request Form

**Medical Services/Supplies:**

- **Commercial, Individual, Medicare, FEP members:** Fax 1 (855) 232-0090
- **Administrative Services Only (ASO) members:** Fax 1 (844) 679-7763

**Behavioral Health Services:** Fax 1 (888) 496-1540
**SNF, LTAC, IP Rehab:** Fax 1 (855) 848-8220
**Mail to:** PO Box 1271, WW5-53, Portland, OR 97207-1271

**Used for skilled nursing (SNF), long term acute care (LTAC), inpatient rehabilitation (IP Rehab), behavioral health services, and medical services including; inpatient and outpatient surgeries, outpatient medical services, transplants, DME and professional services.**

**Instructions:** This form should be filled out by the provider requesting the service or DME. Please complete all applicable fields. Prior to completing this form, please confirm the patient's benefits, eligibility and if pre-authorization is required for the service.

Have you verified if pre-authorization is required? ☐ Yes ☐ No

***Note:** If no, please verify with the pre-authorization list on the Provider Web site or call the number on the back of the member's card. Is this request:

☐ New ☐ Authorization Extension ☐ Providing Additional Information

☐ Medicare Only – Preservice Benefit Organization Determination Request

If you already have an authorization number, please list it here ____________________

**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 physician believes that waiting for a decision under the standard time frame 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 Number |
|---|---|---|---|
| Patient's Regence Member ID Number | Group Number | | Date of Birth (mm/dd/yyyy) |

## SECTION 2 – PROVIDER INFORMATION

Please check one: ☐ Requesting Provider ☐ Rendering Provider ☐ DME Supplier

| Provider Name | | Tax ID Number | |
|---|---|---|---|
| NPI | Phone Number | Confidential Voice Mail ☐ Yes ☐ No | Fax Number |
| Provider Address | City | State | Zip Code |

**Who should we contact if we require additional information?**

| Name | Phone Number Ext. | Confidential Voice Mail ☐ Yes ☐ No | Fax Number |
|---|---|---|---|

## SECTION 3 – PREAUTHORIZATION REQUEST

Is this request: ☐ Pre-Service **or** ☐ Concurrent Review
Date of Service (if scheduled) __________________ (mm/dd/yyyy)

Please check one: ☐ Outpatient Hospital ☐ Inpatient ☐ ASC ☐ Office
☐ Other____________________________________

Please check all that apply: ☐ Surgical ☐ DME ☐ Diagnostic ☐ Medical
☐ Other____________________________________

| Rendering or Treating Provider and Provider Specialty | | | |
|---|---|---|---|
| Physical Address where services will occur | City | State | Zip Code |

| **IF INPATIENT OR OUTPATIENT FACILITY** | | **IF DME** | | |
|---|---|---|---|---|
| Facility Name | | Company Name | | |
| Anticipated Admission (mm/dd/yyyy) | Anticipated Length of stay | Tax ID Number | NPI | |
| **Note:** If anticipated length of stay is not indicated, no more than two days will be assigned if approved. | | DME Address | | |
| | | City | State | Zip Code |
| **Note:** This form does not serve as a notification of admission. Please reference the Provider Web site for instructions to notify us of an admission. | | Signed copy of prescription attached: ☐ Yes ☐ No<br>Invoice attached: ☐ Yes ☐ No | | |

**Please provide all diagnosis, CPT® or HCPCS codes and their descriptions, if available; this will help processing of your request.**

| Diagnosis code(s) and description(s) | CPT® or HCPCS code(s) and description(s) | DME Only Line Item Cost |
|---|---|---|
| Primary: | | **$** |
| Second: | | **$** |
| Third: | | **$** |

**Please submit the following clinical documentation with this form as appropriate for this request:**

- History & Physical
- Lab/Radiology/Testing Results
- Current Symptoms & Functional Impairments
- Treatment History and any other information such as chart notes that support medical necessity for the request.