Regence

Regence BlueShield serves select counties in the state of Washington and 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 ☐ 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
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.