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
DME
Commercial, Individual, Medicare, BCBS FEP members:
Fax: 1 (855) 207-1209
Administrative Services Only (ASO) members:
Fax: 1 (844) 679-7763
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				
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:	
DME Company Name		Tax ID #	NPI #	
Mailing Address		Fax #		
City	State ZIP Code	Phone # Ext.	Confidential Voice Mail ☐ Yes ☐ No	
Email Address		Signed copy of prescription attached: ☐ Yes ☐ No Invoice attached: ☐ Yes ☐ No		

SECTION 3 – PREAUTHORIZATION REQUEST

Date of Service _____

Please check one: ☐ Outpatient Hospital ☐ Inpatient ☐ ASC ☐ Office ☐ Home
☐ Other _____

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

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

- Signed copy of prescription
- Invoice with pricing

  AND
- Specific clinical documentation as outlined in the associated Regence Medical Policy, Policy Guidelines section

  OR
- Specific clinical information documenting the applicable Medicare, or BCBS FEP medical necessity criteria, **including:**
  - History and physical
  - Lab/Radiology/Testing results
  - Current symptoms and functional impairment
  - Treatment history and any other information such as chart notes that support medical necessity for the request

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