

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

### Medical Services/Supplies:

- **Commercial, Individual, Medicare, FEP members:** Fax 1 (855) 207-1209
- **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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No			Fax Number		
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### 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  
 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.