Regence

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

# Pre-Authorization Request Form

**For Uniform Medical Plan (UMP) Members:**
Fax to: 1 (877) 663-7526 **or**
Mail to: PO Box 2998, Tacoma, WA 98401-2998

**For Commercial and Individual Members:**
Fax to: 1 (855) 232-0088 **or**
Mail to: PO Box 1271, MS E9H, Portland, OR 97207-1271

**Used for Durable Medical Equipment (DME), Inpatient and Outpatient Surgeries, and Outpatient Medical 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 ☐ Check for Authorization Status
If you already have an authorization number, please list it here _____

## SECTION 1 - PATIENT INFORMATION

| Patient Name (Last) | First | MI | Patient's Phone Number (xxx) xxx-xxxx |
|---|---|---|---|
| Patient's Regence Member ID Number | Group Number | | Date of Birth (mm/dd/yyyy) (mm/dd/yyyy) |

## SECTION 2 - PROVIDER INFORMATION

Please check one: ☐ Requesting Provider ☐ Rendering Provider

| Provider Name | | Tax ID Number | |
|---|---|---|---|
| NPI | Phone Number (xxx) xxx-xxxx | Fax Number (xxx) xxx-xxxx | |
| Provider Address | City | State State | ZIP Code |

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

| Name | Phone Number (include ext) | Fax Number (xxx) xxx-xxxx |
|---|---|---|

## SECTION 3 - PREAUTHORIZATION REQUEST

Is this request: ☐ Pre-Service **or** ☐ Concurrent Review Date of Service (if scheduled) _____ (mm/dd/yyyy) (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 State | ZIP Code |
|---|---|---|---|

| IF INPATIENT | IF DME | |
|---|---|---|
| Facility Name | Company Name | |
| Anticipated Admission (if scheduled-mm/dd/yyyy) (mm/dd/yyyy) | Tax ID Number | NPI |
| **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. | DME Address | |
| | City | State State / ZIP Code |
| | Signed copy of prescription attached: ☐ Yes ☐ No | Invoice attached: ☐ Yes ☐ No |

**If this is an expedited request and meets the definition indicated below, please check the expedited request box ☐ AND fax this form 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.

**Please provide all ICD-9, CPT® or HCPCS codes and their descriptions, if available; this will help processing of your request.**

| ICD-9 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 information 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.



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