Regence

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

Pre-Authorization Request Form

For Administrative Services Only (ASO) Members:
Fax to: 1 (844) 679-7763 for medical services/supplies and
1-888-496-1540 for behavioral health **or**
Mail to: PO Box 2998, Tacoma, WA 98401-2998

For Commercial and Individual Members:
Fax to: 1 (855) 232-0090 for medical services/supplies and
1-888-496-1540 for behavioral health **or**
Mail to: PO Box 1271, MS WW5-53, Portland, OR 97207-1271

Used for skilled nursing, long term acute care, inpatient rehabilitation, behavioral health services, 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 ☐ 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 ☐ DME Supplier

Provider Name		Tax ID Number	
NPI	Phone Number (xxx) xxx-xxxx	Confidential Voice Mail ☐ Yes ☐ No	Fax Number (xxx) xxx-xxxx
Provider Address	City	State State	ZIP Code xxxxx-xxxx

Who should we contact if we require additional information?

Name	Phone Number (include ext)	Confidential Voice Mail ☐ Yes ☐ No	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 xxxxx-xxxx

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. **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 xxxxx-xxxx
		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 or ASO Fax to 1 (844) 679-7764.
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 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 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.