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

1800 Ninth Avenue
PO Box 21267
Seattle, WA 98111-9230

Pre-Authorization Request Form

For **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 (800) 453-4341, or mail to PO Box 21267, Seattle, WA 98111-9230

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 I: Patient Information

Patient Name Last:__________________________ **First:**__________________________ **MI** ___ **DOB** (MM/DD/YYYY) ____/____/______

Patient's Regence Member ID #______________________________ **and Group Number:**______________________

Section II: Provider Information

Please check one: ☐ Requesting Provider ☐ Rendering Provider

Provider Name____ **Tax ID Number**____________________________

NPI___________________________________ **Phone** (________) ________-__________ **Fax** (________) ________-__________

Provider Address:____

Who should we contact if we require additional information?

Name: ____________________________ **Phone** (_______) _______-_________ **ext.** _____ **Fax** (_______) _______-__________

Section III: Pre-Authorization Request

Is this request: Pre-Service ☐ **or** Concurrent Review ☐ **Date of service** (if scheduled, MM/DD/YY)______/______/_______

Please check one: Outpatient Facility ☐, Inpatient Facility ☐, Office ☐, Other ☐ ________________________________

Please check all that apply: Surgical ☐, DME ☐, Diagnostic ☐, Medical ☐, Other ☐ ____________________________

Rendering or Treating Provider____

Physical Address where services will occur:

Address: ____

City____ **State** ______________ **Zip** ____________

If Inpatient:	**If DME:**
Facility Name: ______________________________________	Company Name____
Anticipated Admission (if scheduled, MM/DD/YY) _________/_________/_________	Tax ID Number______________________NPI___________________ 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

Is this request Urgent? Defined as: A delay of service could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function. -Or- In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment.

If this request is Urgent and meets the definition as indicated above, please check this box: ☐

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 a*ny other information such as chart notes that support medical necessity for the request.*