Regence

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

Pre-authorization Request Form
Medical Services
Commercial, Individual, Medicare, BCBS FEP members:
Fax: 1 (855) 232-0085
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 #
TEST	TEST		503-222-2222

Patient's Regence Member ID #	Group #	Date of Birth
7 1 0 5 7 7 0 5 1	1 0 0 0 3 9 4 8	11/13/1978

SECTION 2 – PROVIDER INFORMATION

Please check one: ☐ Requesting/Prescribing Provider ☒ Rendering/Treating Provider

Provider Name		Tax ID #	
Deepali Jain		91-1939739	
NPI #	**Office Phone #**	**Confidential Voice Mail**	**Fax #**
1013203082	503-222-2222	☐ Yes ☒ No	503-333-3333
Mailing Address		**City**	**State / ZIP Code**
11511 Canterwood BLVD Suite 140		Gig Harbor	WA 98332
Provider Specialty		**Email Address**	
General Surgery			

Who should we contact if we require additional information?

Name	Phone # 503-222-2222	Confidential Voice Mail	Fax #
Jennifer	Ext.	☒ Yes ☐ No	503-111-1111

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 #:	Date:	Date:	Date:
Ext:	Time:	Time:	Time:

Facility or Independent Laboratory Name			Tax ID #	NPI #
St Anthony Hospital			383769889	1447406699
Mailing Address			**Fax #**	
11567 Canterwood BLVD			360-123-4567	
City	**State**	**ZIP Code**	**Phone # 360-111-2222**	**Confidential Voice Mail**
Gig Harbor	WA	98332	Ext.	☐ Yes ☒ No

SECTION 3 – PREAUTHORIZATION REQUEST

Date of Service/Anticipated Admission 4/10

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

Note: This form does not serve as a notification of admission. Please reference our provider website for instructions about how to notify us of an admission.

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: K439	49591
Second:	
Third:	

SECTION 4 – DOCUMENTATION SUBMISSION

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

- 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.