



1602 21st Avenue
 P.O. Box 1106
 Lewiston, ID 83501-1106

Pre-Authorization Request Form

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

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 (800) 453-4341, or mail to
 PO Box 1106, Lewiston, ID 83501-1106

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 _____
<i>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.</i>	DME address _____
	City _____ State _____ Zip Code _____
	Signed copy of prescription attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Invoice attached: <input type="checkbox"/> Yes <input type="checkbox"/> 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 any other information such as chart notes that support medical necessity for the request.