



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

**Pre-authorization Request Form
Medicare Home Health
Fax: 1 (855) 232-0088
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.

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 physician 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 #	
Patient's Regence Member ID #					Group #					Date of Birth
SECTION 2 – PROVIDER INFORMATION										
Requesting/Prescribing Provider Name					Tax ID #					
NPI #		Office Phone #			Confidential Voice Mail <input type="checkbox"/> Yes <input type="checkbox"/> No			Fax #		
Mailing Address					City			State	ZIP Code	
Provider Specialty					Email Address					
Who should we contact if we require additional information?										
Name		Phone # Ext.			Confidential Voice Mail <input type="checkbox"/> Yes <input type="checkbox"/> No			Fax #		
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:		
Home Health Agency Name					Tax ID #			NPI #		
Mailing Address					Fax #					
City		State	ZIP Code		Phone # Ext.			Confidential Voice Mail <input type="checkbox"/> Yes <input type="checkbox"/> No		
Email Address					Outcome and Assessment Information Set (OASIS) and Medication Reconciliation Form Included? <input type="checkbox"/> Yes <input type="checkbox"/> No					

SECTION 3 – PREAUTHORIZATION REQUEST

Dates of Service _____

Episode Requested: 1 (Day 0-60) 2 (Day 61-120) 3+ (Day 120 and beyond)**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:	
Second:	
Third:	

SECTION 4 – DOCUMENTATION SUBMISSION**Submit the following documentation, as appropriate, with this request:**

- Outcome and Assessment Information Set (OASIS)
 - Medication Reconciliation Form
- AND**
- 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.