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

Fax submission exception form

Use this form *only* when submitting an approved fax exception. Review our exception criteria prior to submission to ensure eligibility. **Submissions that do not meet the criteria will not be processed.**

Do not use for pricing disputes. A pricing dispute occurs when there is a disagreement with the contractual pricing of a claim line item. Use the pricing dispute process on our provider website, **regence.com**: Claims and Payment>Receiving Payment>Pricing Disputes and Appeals.

Medicare Submissions: We encourage electronic submission through Availity Essentials for all lines of business. However, to meet Medicare requirements, we have an exception process available for fax submission.

Complete all required fields before faxing. Incomplete or blank forms will not be processed.	
Select the exception reason and provide brief details below.	
Reason Required:	
☐ Availity Essentials unavailable	☐ Natural disaster
☐ File size too large to submit via Availity Essentials	☐ Provider location lacks internet
Note: Large provider appeals files may be submitted via mail or SFTP	☐ Extenuating circumstance exception for not obtaining pre-authorization (pre-claim)
☐ Coordination of Benefits for utilization management review	☐ Medicare LOB
Brief Description (Required):	

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For Exceptions Only Pre-authorization Request Form
DME
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 1106
Lewiston ID 83501-1106

Requests are required to be received using Availity. Faxed authorizations are only permitted by exception.

Instructions: This form should be completed and filled out by the requesting provider, only if an exception applies. 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 #
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 ☐ Yes ☐ 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 ☐ Yes ☐ 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 #: Ext:	Date: Time:	Date: Time:	Date: Time:

DME Company Name			Tax ID #	NPI #
Mailing Address			Fax #	
City	State	ZIP Code	Phone # Ext.	Confidential Voice Mail ☐ Yes ☐ No
Email Address			Signed copy of prescription attached: ☐ Yes ☐ No Invoice attached: ☐ Yes ☐ No	

SECTION 3 – PREAUTHORIZATION REQUEST

Date of Service ____________________________

Please check one: ☐ Outpatient Hospital ☐ Inpatient ☐ ASC ☐ Office ☐ Home
☐ Other ____________________________

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:

- Signed copy of prescription
- Invoice with pricing

  AND
- 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.