Regence

Regence BlueShield serves select counties in the state of Washington and 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
- ☐ File size too large to submit via Availity Essentials
  Note: Large provider appeals files may be submitted via mail or SFTP
- ☐ Coordination of Benefits for utilization management review
- ☐ Natural disaster
- ☐ Provider location lacks internet
- ☐ Extenuating circumstance exception for not obtaining pre-authorization (pre-claim)
- ☐ Medicare LOB

Brief description (required):

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For Exceptions Only Pre-authorization Request Form
Medical Services
Commercial, Individual, Medicare, BCBS FEP members:
Fax: 1-855-207-1209
Administrative Services Only (ASO) members:
Fax: 1-844-679-7763
Mail to: P.O. Box 1106
Lewiston, ID 83501-1106

Requests are required to be received using Availity. Faxed authorizations are only permitted by exception. Please review exception criteria for full details:

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

Facility or Independent Laboratory Name			Tax ID #	NPI #
Mailing Address			Fax #	
City	State	ZIP Code	Phone # Ext.	Confidential Voice Mail ☐ Yes ☐ No

SECTION 3 – PREAUTHORIZATION REQUEST

Date of Service/Anticipated Admission _____

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:	
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.