

Prior Authorization Form

Download, complete, and fax to 800-843-1114.

Starting July 1, 2021, all handwritten, faxed forms will be returned without processing. Please check codes online to confirm if a review is required before submitting a prior authorization request.

For the fastest response, sign in and use our secure online tools at premera.com/ak/provider for the following requests:

- Patient eligibility
- Prior authorization code checks
- Prior authorization
- Status checks, even if faxed prior (for in-area providers only)

A screenshot (with date) of the information found online can be used for verification documentation in case of appeal.

For providers in Alaska:

Get everything you need to know about Premera prior authorization at premera.com/ak/provider/utilization-review/about-prior-authorization/.

For providers outside of Alaska:

Visit your local Blue plan's provider website or premera.com/ak/provider/outside-washington-alaska/.

Note: Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.

Confidentiality Notice: The information contained in this fax message is privileged or confidential and intended only for the individual or entity named above. If the reader isn't the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you're hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you've received this communication in error, please call us immediately at 877-342-5258.

**PRE-SERVICE/
PRIOR AUTHORIZATION
REVIEW REQUEST FORM**

Complete and fax to:
800-843-1114
(Handwritten faxes not
accepted.)



Request date: _____

MEMBER/PATIENT: _____ Date of birth: _____
Member ID: _____ Suffix: _____ Group #: _____

<p>REQUESTING PROVIDER: _____ Address: _____ City/State/ZIP: _____ Phone: _____ Fax: _____ Contact person: _____ Tax ID (required): _____ NPI # (if available): _____</p>	<p>SERVICING PROVIDER: _____ Address: _____ City/State/ZIP: _____ Phone: _____ Fax: _____ Contact person: _____ Tax ID (required): _____ NPI # (if available): _____</p>
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REQUIRED: Complete all fields that apply for place of service. To enable SOS boxes download form before completing

<p>FACILITY: _____ Address: _____ City/State/ZIP: _____ Tax ID (required): _____ NPI # (if available): _____ Phone: _____ Fax: _____</p>	<p><input type="checkbox"/> Outpatient hospital <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Office <input type="checkbox"/> Ambulatory surgical center <input type="checkbox"/> Ongoing treatment * For medical and psychiatric lower levels of care, use our Admission/Concurrent Review Fax Form. Date scheduled: _____ Existing reference #: _____ Expiration date: _____</p>
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URGENT REQUEST
PLEASE NOTE: Scheduling issues do not meet the definition of urgent.
Urgent requests must be signed and include supporting documentation from the provider's office, noting that standard timeframes for making a non-urgent determination could:

- Seriously jeopardize the life/health of the patient or the ability to regain maximum function, **or**
- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, **or**
- In the opinion of a provider with knowledge of the member's medical or behavioral condition, subject the patient to adverse health consequences without the requested care or treatment.

I attest that this request meets the urgent definition described above: MD signature: _____

CLINICAL INFORMATION required. Attach supporting medical records and include presenting symptoms and previous treatment.

Procedure code/CPT code:	Modifier: (LT/RT/ NU/RR)	ICD diagnosis code:

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