IMPORTANT INSTRUCTIONS PLEASE DOWNLOAD THIS FORM

Please note we will only be accepting electronic and not handwritten forms starting 6/1/2021. For faster and more efficient processing please submit via the online portal.

We are asking Providers to use our online tools for the following requests. Please check codes online to confirm a review is required before submitting a prior authorization request. This will help ensure we are able to get to qualifying requests in a timely manner. We also encourage you to submit your Prior Authorization Request on the Portal for faster processing.

- Patient Eligibility
- Prior Authorization Code Checks
- Prior Authorizations
- Status checks, even if faxed prior (for in area providers only)

A screenshot with the date included of the information found online can be used for verification documentation in the event you need to appeal.

For providers in Washington, Alaska:

Check it out today at: WA: premera.com/wa/provider/utilization-review/about-prior-authorization/ AK: premera.com/ak/provider/utilization-review/about-prior-authorization/

For providers outside of Washington, Alaska:
Visit your local Blue plan's provider website or go to:
WA: premera.com/wa/provider/outside-washington-alaska/
AK: premera.com/ak/provider/outside-washington-alaska/

PRE-SERVICE/
PRIOR AUTHORIZATION
REVIEW REQUEST – DME

Fax to Care Management:
800-843-1114

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

HOME MEDICAL EQUIPMENT/PROSTHETICS/ORTHOTICS

Request Date _____

☐ **URGENT** – All requests marked as urgent/expedited must include supporting documentation from the physician's office that the application of standard timeframes for making a non-urgent determination: (a) could seriously jeopardize the life or health of the patient or the ability to regain maximum function, or, (b) in the opinion of a physician with knowledge of the member's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment being requested.

MEMBER/PATIENT _____ Date of Birth _____
Member ID _____ Suffix _____ Group # _____

REQUESTING PROVIDER _____	**SERVICING PROVIDER** _____
Address _____	Address _____
City/State/ZIP _____	City/State/ZIP _____
Phone _____ Fax _____	Phone _____ Fax _____
Optional information below *– please include if known.*	***Optional information below*** *– please include if known.*
Contact Person _____	Contact Person _____
Tax ID/NPI # _____	Tax ID/NPI # _____
Contracted Provider: ☐ Yes ☐ No	Contracted Provider: ☐ Yes ☐ No

PRESCRIPTION AND DOCUMENTATION OF MEDICAL NECESSITY REQUIRED

ICD Diagnosis _____ Facility Name _____
Provider comments _____
Existing Reference # _____ **Expiration Date** _____

HCPCS Code	Requested Item	Quantity/ Length of Supply	Purchase Price	Rental Fee	Length of Rental

Anticipated Delivery Date _____

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.