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/

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.

OUT-OF-NETWORK PRE-AUTHORIZATION AND EXCEPTION REQUEST FORM
This form is for out-of-network providers requesting application of in-network benefits for their services.

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Complete and fax to Care Management at 800-866-4198.

Request Date: _____

☐ **URGENT** – Urgent requests must 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, in the opinion of a provider with knowledge of the member's medical condition, subject the patient to severe pain that they can't adequately manage without requesting care or treatment.

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: _____
Contact person: _____	Contact person: _____
Tax ID (REQUIRED): _____	Tax ID (REQUIRED): _____
NPI # (if available): _____	NPI # (if available): _____

REQUIRED: Complete all fields that apply for place of service.

FACILITY: _____	☐ Outpatient hospital
Address: _____	☐ Inpatient hospital
City/State/ZIP: _____	☐ Ambulatory surgical center
Tax ID (REQUIRED): _____	☐ Ongoing treatment
NPI# (if available): _____	**Date scheduled:** _____
Phone: _____ Fax: _____	**Existing reference #:** _____
	Expiration date: _____

Reason for out-of-network provider request:

What is the reason for the request?

Has the patient seen this provider in the past? Yes ☐ / No ☐ If yes, when was the last visit?

Is this request a follow-up to an emergency? (e.g., ER treatment/emergency surgery) Yes ☐/ No ☐
If yes, when was the last visit?

Service needed (procedure, test, inpatient care – please specify). Attach supporting medical records and include presenting symptoms and previous treatment.

Diagnosis code(s): Procedure/CPT code(s):

Explain in detail why the services noted above can only be provided by this particular out-of network provider:

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