PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

FAX TO UM
If questions, please call UM

Alaska Members
UM Fax: 888-584-8081
UM Phone: 844-996-0332

Requestor's Contact Name:				Requestor's Contact #:					
Patient Information:									
*Name:				*DOB:					
*Member ID #:				*Member Phone #:					
Work Related Injury?	☐	Yes	☐	No	Motor Vehicle Accident related injury?	☐	Yes	☐	No
Does the member have other insurance?	☐	Yes	☐	No	If Yes, other insurer				
Does the member have Medicare?	☐	Yes	☐	No	If Yes,	☐	Part A	☐	Part B

*Service Is: ☐ Elective / Routine ☐ Expedited / Urgent ☐ Retrospective review

Note: Select Expedited/Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function.

(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at **1-800-809-9361)**

***Referral Service Type Requested:** Please review plans benefit prior to request

Inpatient	Outpatient	Behavioral Health	Other
☐ Emergent Inpatient	☐ Surgical Procedure	☐ Inpatient	☐ Home Health /Skilled Services (SN/PT/OT/SP)
☐ Concurrent Review	☐ PT, OT, ST	☐ Partial Hospitalization	☐ Private Duty Nursing
☐ Surgical Procedures	☐ Imaging	☐ Intensive Outpatient (IOP)	☐ DME
☐ Elective Admission	☐ Chiropractic	☐ Residential Treatment	☐ Transportation / Transfers
☐ Elective Observation		☐ Mental Health & Substance Use Disorder	☐ Air Ambulance
☐ SNF		☐ ABA Therapy/Services	☐ Other:
☐ Rehab		☐ Other Therapy:	
☐ Maternity			
☐ NICU			

Procedure Information:

*__ICD 10__ Diagnosis: Diagnosis Description:

*__CPT/HCPC__ Code & Description *(Include Unit of Measure / Frequency for supplies):*

*Date(s) of Service: Number of Visits:

Provider Information:

Ordering Provider	Is this the member's Primary Care Physician? ☐ Yes ☐ No	
*Name:	*NPI:	TIN:
*Phone:	*Fax:	
*Address:		
Servicing Provider	Is this the same as the Ordering Provider? ☐ Yes ☐ No	
If not complete below:		
*Name:	*NPI:	TIN:
*Phone:	*Fax:	
*Address:		
Facility		
*Name:	*NPI:	TIN:
*Phone:	*Fax:	
*Address:		

Request for extension to authorization request:

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS. Always verify eligibility, benefits and prior authorization requirements