PREMERA BLUE CROSS

FAX TO UM
If questions, please call UM

Washington Members
UM Fax: 888-302-9325
UM Phone: 844-996-0329

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 **1-800-607-0546)**

***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)	
☐ Elective Admission	☐ Chiropractic	☐ Residential Treatment	☐ DME
☐ Elective Observation		☐ Mental Health & Substance Use Disorder	☐ Transportation / Transfers
☐ SNF		☐ ABA Therapy/Services	☐ Air Ambulance
☐ Rehab		☐ Other Therapy:	☐ Other:
☐ 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