PREMERA HMO

Pre-service/Prior Authorization Review Request

Instructions

- Download this form to complete it. For expedited response, please use the Availity site for authorization requests.
- This form must NOT be handwritten.
- Use the following number for faxing. This form must be the first two pages of the fax submission.
    - PBC fax: 800-843-1114

A. Member/patient information

Member/patient name			Date of birth
Member ID Number Details	Alpha prefix	ID Number	Suffix

B. Urgent request: Note scheduling issues do not meet the definition of urgent.

☐ Check this box if this is an urgent request.

Urgent requests must be signed by the requesting provider and include supporting documentation from the provider's office, Services more than five days out are not considered urgent. Note: 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.

MD Signature: **I attest that this request meets the urgent definition described above.**	Print name	
X _____	Print title	Date signed

C. Provider information: Every field in this section is required.

Name of requesting provider		Contact person	
Address	City	State	ZIP code
Phone number with area code		Fax number with area code	
Tax ID		NPI number	

Is the servicing provider the same as the requesting provider?

◯ Yes. Skip to section D.

◯ No. Continue with servicing provider information below. This information is required.

Name of servicing provider		Contact person	
Address	City	State	ZIP code
Phone number with area code		Fax number with area code	
Tax ID:		NPI number	

D. Substance Use Disorder Providers

Part 2 providers are required to obtain written patient consent before submitting records and to include notice required under federal confidentiality rules (42 CFR part 2).

E. Facility information

Select the type of facility

- ◯ Outpatient hospital
  - (Required) Does provider have privileges at an ASC within 30 miles? ◯ Yes ◯ No
  - If yes, provide reason for exception:
  - ☐ Necessary equipment is unavailable
  - ☐ Individual is ≤ 18 years of age
  - ☐ Guidelines prohibit ASC due to health condition or BMI ≥ 50
  - ☐ Additional services being performed require outpatient hospital department
  - ☐ Other:_____
- ◯ Inpatient hospital
- ◯ Ambulatory surgical center
- ◯ Freestanding infusion center
- ◯ Home
- ◯ Office
- ◯ Other: _____

Name of facility	Contact person		
Address	City	State	ZIP code
Phone number with area code	Fax number with area code		
Tax ID (required):	NPI # (required)		

F. Clinical information

Date scheduled	Existing reference number	Expiration date
Attach supporting medical records and include presenting symptoms and previous treatment.		

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

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.

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