

For **Uniform Medical Plan (UMP)** members:  
 Fax to 1 (877) 663-7526, or mail to  
 PO BOX 2998, Tacoma, WA 98401-2998

For **Commercial and Individual** members:  
 Fax to 1 (800) 453-4341, or mail to  
 PO Box 1271, Portland, OR 97201-1271

**Used for Durable Medical Equipment (DME), Inpatient and Outpatient Surgeries, and Outpatient Medical Services**

**Instructions:** This form should be filled out by the provider requesting the service or DME. Please complete all applicable fields. Prior to completing this form, please confirm the patient's benefits, eligibility and if pre-authorization is required for the service.

Have you verified if pre-authorization is required?  Yes  No

*\*Note: If no, please verify with the pre-authorization list on the [Provider Web site](#) or call the number on the back of the member's card.*

Is this request:  New  Authorization Extension  Providing Additional Information  Check for Authorization Status

If you already have an authorization number, please list it here: \_\_\_\_\_

**Section I: Patient Information**

Patient Name Last: \_\_\_\_\_ First: \_\_\_\_\_ MI \_\_\_\_\_ DOB (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Regence Member ID # \_\_\_\_\_ and Group Number: \_\_\_\_\_

**Section II: Provider Information**

Please check one:  Requesting Provider  Rendering Provider

Provider Name \_\_\_\_\_ Tax ID Number \_\_\_\_\_

NPI \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Provider Address: \_\_\_\_\_

Who should we contact if we require additional information?

Name: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Section III: Pre-Authorization Request**

Is this request: Pre-Service  or Concurrent Review  Date of service (if scheduled, MM/DD/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Please check one: Outpatient Facility , Inpatient Facility , Office , Other  \_\_\_\_\_

Please check all that apply: Surgical , DME , Diagnostic , Medical , Other  \_\_\_\_\_

Rendering or Treating Provider \_\_\_\_\_

Physical Address where services will occur:

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If Inpatient:	If DME:
Facility Name: _____	Company Name _____
Anticipated Admission (if scheduled, MM/DD/YY) ____/____/____	Tax ID Number _____ NPI _____
<i>Note: This form does not serve as a notification of admission. Please reference the <a href="#">Provider Web site</a> for instructions to notify us of an admission.</i>	DME address _____
	City _____ State _____ Zip Code _____
	Signed copy of prescription attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Invoice attached: <input type="checkbox"/> Yes <input type="checkbox"/> No

**Is this request Urgent?** Defined as: A delay of service could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function. -Or- In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment.

**If this request is Urgent and meets the definition as indicated above, please check this box:**

**Please provide all ICD-9, CPT® or HCPCS codes and their descriptions, if available; this will help processing of your request.**

ICD-9 code(s) and description(s)	CPT® or HCPCS code(s) and description(s)	DME Only Line Item Cost
Primary:		\$
Second:		\$
Third:		\$

**Please submit the following clinical information with this form as appropriate for this request:**

- History & Physical • Lab/Radiology/Testing Results • Current Symptoms & Functional Impairments • Treatment History • and any other information such as chart notes that support medical necessity for the request.