

Predetermination Request Form

— Confidential —

Date Submitted: _____ Pages attached (include cover and/or form): _____

Contact Name: _____ Contact Phone #: _____ Contact Fax #: _____

**** Please be sure contact fax number is clear due to HIPAA, since decision letters will be faxed to the provider.**

Please complete this form and submit with clinical when requesting predetermination of benefits for a specific procedure or service. If the determination of this review will influence the decision to proceed with treatment, BlueCross BlueShield of Tennessee recommends that nothing be scheduled until the final determination has been issued. A request for predetermination is not necessary for urgent or emergency medical treatment.

Predetermination requests are never required and are offered as a courtesy review to check for possible pre-existing conditions, benefits/coverage, and to ensure services meet medical criteria/guidelines. They do not take the place of any precertification/prior authorization requirements. Failure to obtain any necessary authorizations may result in a denial or reduction in benefits.

| | |
|--|-------------------|
| Member Name: | Member ID Number: |
| Date of Birth (mm/dd/yy): | Male Female |
| Diagnosis (including ICD-9-CM Code): | |
| Procedure: Office Outpatient | |
| Regarding lab panel tests/or genetic panels: | |
| Are these codes part of a panel(s)? Yes No | |
| If part of a panel or panels – what is the name of the panel(s)? | |

Requesting provider information below:

| | | |
|----------------------|---------------|------------|
| Requesting Provider: | Provider No.: | NPI No: |
| Telephone No.: | Fax No.: | |
| Address: | City: | State/Zip: |

Requested Procedure(s) or Equipment:

CPT® or HCPCS Codes (required):

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| | |

Codes continue on next page

