



## **Instructions for submitting REQUESTS FOR PREDETERMINATIONS**

A **predetermination of benefits** is a voluntary, written request for review of treatment or services that may be considered experimental, investigational or cosmetic. Predetermination approvals and denials are usually based on provisions in our medical policies. BCBSIL will notify the provider when the final outcome has been reached.

### **Use this form to request:**

- A predetermination of benefits prior to rendering the services.
- An appeal of a previously denied predetermination of benefits.

### **IMPORTANT PREDETERMINATION REMINDERS**

1. Always verify eligibility and benefits first.
  - A predetermination is not required for all procedures, such as complete or partial bony impacted teeth.
  - You must also complete any other pre-service requirements, such as pre-certification, if applicable and required.
2. Fill out the entire Predetermination Request Form. **All fields are required.\***
  - Be sure to include the provider's address and fax number.
  - Include a contact name, address and phone number.
  - Always provide the procedure code and the diagnosis code.
  - If applicable, provide left, right or bilateral.
  - For Major Diagnostic Tests, include the patient's history, physical and any prior testing information.
3. You **MUST** submit the predetermination to the Blue Cross and Blue Shield (BCBS) Plan that holds the patient's policy.
4. Fax information for each patient separately, using the fax number indicated on the form.
5. Always place the Predetermination Request Form on top of other supporting documentation.
6. Do not send in duplicate requests, which may only delay the process.
7. Per BCBSIL Medical Policy, if photos are required for review, the photos should be mailed along with the predetermination and not faxed. Faxed photos are not legible and cannot be used to make a determination.
8. To be notified via fax for the determination, please provide a contact name and fax number under the "Provider Data" section of the form. Also, a letter will be mailed the day the determination is finalized.

**Note:** To submit a predetermination for Synagis, use the appropriate form found at [http://bcbsil.com/provider/pharmacy/pharmacy\\_index.html](http://bcbsil.com/provider/pharmacy/pharmacy_index.html)

***Fax each completed Predetermination Request Form to 800-852-1360  
If unable to fax, you may mail your request to BCBSIL, PO BOX 805107, Chicago, IL 60680-4112.***

\*Inquiries received without the member/patient's group and ID number cannot be completed and may be returned to you to supply this information. **It is important that all fields on the form be completed.** If all information is not provided, this may cause a delay in the predetermination process.

Please note that the fact that a guideline is available for any given treatment, or that a service or treatment has been pre-certified or predetermined for benefits, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.



# Predetermination Request Form

Fax the completed form to 800-852-1360

*Predetermination requests will only be accepted at the dedicated fax number.*

Critical <input type="checkbox"/> (Check if service is listed below)	Other <input type="checkbox"/> (Check if service is not on the critical list)
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Critical List: Bariatric Surgery Repair Breast MRI	Cancer Related Treatment Chemotherapy/Radiation EO935 CPM Device	Hyperbaric Oxygen Therapy IMRT PET Scan	Transplants
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### PROVIDER DATA

Date:	___ / ___ / ___	Name of Provider/Group:						
Rendering Physician Provider Type:								
Billing NPI Number: (If applicable – Must be 10 digits)								
Contracting Status:	PPO <input type="checkbox"/>	Non-Par <input type="checkbox"/>	Email Address:					
Contact First Name:			Contact Last Name:					
Telephone Number:	( )	Fax Number:	( )					
Street Address:								
City:		State:		Zip Code:				

### MEMBER DATA

Member Identification Number: (Include alpha prefix)									
Group Number:		Patient's Date of Birth:							
Member's First Name:			Member's Last Name:						
Patient's First Name:			Patient's Last Name:						

### Documentation: Attach any documentation that supports or facilitates your review. The following information is required for review. Check all that apply.

Place of treatment:	Office <input type="checkbox"/>	Outpatient <input type="checkbox"/>	Inpatient <input type="checkbox"/>	Home <input type="checkbox"/>	
Evaluation/Health History <input type="checkbox"/>	Office/Therapy Notes <input type="checkbox"/>				
CPT Procedure code(s):	ICD-9 Diagnosis code(s):				
		<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral	<input type="checkbox"/> N/A

Other:
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