

Predetermination Request Form Instructions

Do not use this form for services that require Prior Authorization

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| Before Completing This Form | <ol style="list-style-type: none"> 1. Verify the member’s eligibility and benefits first. Make sure the member has active coverage with this plan and has benefit coverage for the service you are requesting. 2. Review the Medical Policy for the requested services, if applicable, by using our Medical Policy Search engine found at bluecrossmn.com/providers. Select “Medical Policy” in Tools & Resources section of the page. 3. If you are a participating provider with Blue Cross and Blue Shield of Minnesota, you must submit an Authorization request online prior to requesting a predetermination. By doing this, you will ensure that the member’s plan does not require prior authorization for the service you are requesting. <i>Out-of-state providers that participate with any Blue Cross and Blue Shield plan can access Availity through the out-of-area member router provided by each state’s plan.</i> |
| When to Request a Predetermination | <p>Predeterminations are <u>not</u> required. A predetermination is a voluntary, written request by a provider to determine if a proposed treatment or service is medically necessary and appropriate. Predetermination approvals and denials are usually based on our medical policy criteria.</p> <p>Predetermination disclaimer:</p> <ul style="list-style-type: none"> • Claims for services that are not on our prior authorization list will process through the claims system according to the member’s benefits with or without a predetermination. • The fact that a guideline is available or that a service or treatment is considered medically necessary and appropriate does not guarantee 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 health plan coverage applicable on the date the service was rendered including any applicable copays and/or deductibles, preexisting condition limitations, contract exclusions and health plan allowed amounts. • An approved predetermination does not guarantee services will apply towards the member’s in-network coverage of benefits. To request a network exception related to a care access issue, please have the member call the customer service number on the back of his/her member ID card. <p>Please <u>do not</u> use this form for:</p> <ul style="list-style-type: none"> • Requests that meet the federal definition of “Urgent” where applying the standard review time may seriously jeopardize the life or health of the member or the member’s ability to regain maximum function. Claims for these services will process through the claims system according to the member’s benefits. All predetermination requests are considered non-urgent. • Medicare, Medical Assistance or Federal Employee Plan members. All requests for these members should be submitted as a Prior Authorization request. |



Predetermination Request Form

Use this form to request a medical necessity review for a service or item that is **NOT** on our Prior Authorization List

Fax form and relevant clinical documentation to **(651) 662-6054**
 Or mail to: Utilization Management, P.O. Box 64265, St. Paul, MN 55164

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|---|--|------------------|-------------------------------|------------------------|----------------------|--------------------------------|
| Patient Information | Member ID: _____ | | Group number: _____ | | | |
| | Member name: _____ | | Date of birth: _____ | | | |
| | Member address: _____ | | | | | |
| | Member city/state/zip: _____ | | | | | |
| | Member phone: _____ | | | | | |
| | Reason for predetermination: <input type="checkbox"/> Non-participating provider <input type="checkbox"/> High cost procedure/member liability <input type="checkbox"/> Investigative or experimental procedure <input type="checkbox"/> Other: _____ | | | | | |
| Availity authorization reference number*: _____ | | | | | | |
| Servicing/DME Provider Information | Contact person: _____ | | Phone: _____ | | | |
| | Servicing provider name: _____ | | | | | |
| | Servicing provider ID/NPI number: _____ | | | | | |
| | Servicing provider address: _____ | | | | | |
| | City/state/zip: _____ | | | | | |
| | Servicing provider phone: _____ | | Servicing provider fax: _____ | | | |
| | Facility name: _____ | | Facility ID: _____ | | | |
| Ordering Provider Information | Ordering provider name: _____ | | | | | |
| | Ordering provider ID/NPI number: _____ | | | | | |
| | Ordering provider address: _____ | | | | | |
| | City/state/zip: _____ | | | | | |
| | Ordering provider phone: _____ | | Ordering provider fax: _____ | | | |
| Services/Procedures/Items Requested | HCPC/CPT Code | Code Description | ICD-10 Diagnosis Code | Start Date mm/dd/yy | End Date mm/dd/yy | DME Charge Information/MSRP |
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| Total pages faxed: _____ | | | | | | |
| *Predetermination requests from participating providers will only be accepted when the response from the corresponding Authorization request in Availity.com is "No Prior Authorization Required." | | | | | | |