BlueCross BlueShield of Texas

Instructions for Submitting REQUESTS FOR PREDETERMINATIONS

Predeterminations typically are not required. A predetermination is a voluntary, written request by a provider to determine if a proposed treatment or service is covered under a patient's health benefit plan. Predetermination approvals and denials are usually based on our medical policies. ***View medical policies.*** The provider and member will be notified when the final outcome has been reached.

Urgent care requests include any request for a predetermination with respect to which the application of the time periods for making non-urgent care determinations;

a. could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function,

or

b. in the opinion of a physician with knowledge of the consumer's medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

IMPORTANT PREDETERMINATION REMINDERS

1. Always verify eligibility and benefits first.

2. You must also complete any other pre-service requirements, such as preauthorization, if applicable and required.

3. All applicable fields are required. If all information is not provided, this may cause a delay in the predetermination process. (Inquiries received without the member/patient's group number, ID number, and date of birth cannot be completed and may be returned to you to supply this information.)

4. You MUST submit the predetermination to the Blue Cross and Blue Shield Plan that issues or administers the patient's health benefit plan.

5. Fax information for each patient separately, using the fax number indicated on the form.

6. Always place the Predetermination Request Form on top of other supporting documentation. Please include any additional comments if needed with supporting documentation.

7. Do not send in duplicate requests, as this may delay the process.

8. Per Medical Policy, if photos are required for review, the photos should be mailed along with the Predetermination Request Form and not faxed. Faxed photos are not legible and cannot be used to make a determination.

9. Fax each completed Predetermination Request Form to 888-579-7935.
If unable to fax, you may mail your request to BCBSTX, P.O. Box 660044, Dallas, TX, 75266-0044.

10. For Federal Employee Program members, fax each completed Predetermination Request Form to 888-368-3406.
If unable to fax, you may mail your request to BCBSTX, P.O. Box 660044, Dallas, TX, 75266-0044.

This form does not apply to Blue Cross Medicare Advantage HMO℠ and Blue Cross Medicare Advantage PPO℠.

BlueCross BlueShield of Texas

FOR INTERNAL USE ONLY
PRED
(Work Item Type)

Predetermination Request Form – Medical and Surgical

It is important to read all instructions before completing this form. This form cannot be used for verification of benefits or to request an appeal of non-certification determination.

Please note that the fact that a guideline is available for any given treatment or that a service or treatment has been preauthorized 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 the service was rendered.

You will receive written notification once a determination has been made.

Urgent ☐	Non-urgent ☐

Today's Date: / /	Scheduled/Anticipated Service Date: / /

PROVIDER DATA

Submitter Information

Submitting Provider:			
Contact First Name:		Contact Last Name:	
Telephone Number:			

Ordering Physician

Ordering Physician: (Individual – Type 1 NPI)											
Ordering Physician First Name:		Ordering Physician Last Name:	
Contact First Name:		Contact Last Name:	
Telephone Number:		Fax Number:	
Street Address:			
City:	State:	Zip:	

Rendering Provider/Facility

Rendering Facility/Physician/Provider: (Organization – Type 2 NPI) (Must be 10 digits)										
Rendering Physician Provider Type:										
Rendering Provider/Facility Name:										
Contact First Name:		Contact Last Name:	
Telephone Number:		Fax Number:	
Street Address:			
City:	State:	Zip:	

MEMBER DATA

Member Identification Number: (Include the 3-digit prefix)												
Group Number:												
Member's First Name:		Member's Last Name:	
Patient's First Name:		Patient's Last Name:	
Patient's Date of Birth:	/ /		

DOCUMENTATION:

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

Place of Treatment:	Provider Office ☐	Outpatient Facility ☐	Inpatient Facility ☐	Home ☐	Office ☐	Other ☐

Evaluation/Health History ☐	Office/Therapy Notes ☐

Procedure Code(s):		Diagnosis Codes:			
Additional Procedure Code(s):		Left ☐	Right ☐	Bilateral ☐	N/A ☐