PLEASE COMPLETE FORM AND ATTACH WITH CLINICAL RECORDS
Fax 877-442-1102

Please contact the benefit department via the phone number on the insureds medical ID card for benefits on the procedure you are inquiring on. A predetermination review or when reviews are not needed does not guarantee benefits. Benefit department would advise level of coverage or if care is non-covered within the plan the patient has.

To: PRE- DETERMINATION DEPT
From: _____

Patient name: _____ Patient's DOB: _____
ID # _____ Group#_____

Ordering Physician:_____Credentials: _____
Address: _____
City:_____State:_____Zip:_____
Phone #: _____
FAX: _____
NPIN_____

Facility: _____
Facility Tax Id:_____
Facility address: _____
Facility phone#: _____

DATE OF SERVICE: _____
ICD-10: _____
Cost for genetic testing, DME equip cost, or cost of drug_____
CPT CODE (5 digit code): enter number of sessions desired for each CPT requested:
CPT: (_____) x ( ) sessions starting date ( ) to ending date ( )
CPT: (_____) x ( ) sessions starting date ( ) to ending date ( )
CPT: (_____) x ( ) sessions starting date ( ) to ending date ( )

FOR PT/OT/ST/ABA
How many visits has patient used? _____
Prior case # on file: _____

***** PLEASE NOTE THIS IS ONLY FOR PRE DETERMINATION OF SERVICES. CLAIMS NEED TO BE FAXED TO 877-291-3247. *****