BlueCross BlueShield of Illinois

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. Please do not fax photographs. If additional information is required, i.e. photographs or digital images, we will request that you send them via mail.
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

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.

BlueCross BlueShield of Illinois

FOR INTERNAL USE ONLY
PRED
(Work Item Type)

Predetermination Request Form

Fax the completed form to (800) 852-1360

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

BlueCard® (Out-of-area) Program Reminder: Predetermination requests for members with BCBS benefits in another state should be sent to the Plan indicated on the member's ID card.

Critical ☐ *(Check if service is listed below)*	Other ☐ *(Check if service is not on the critical list)*

Critical List:

Bariatric Surgery Repair	Cancer Related Treatment	Hyperbaric Oxygen Therapy	PET Scan
Breast MRI	Chemotherapy/Radiation	IMRT	Synagis
	E0935 CPM Device	IVIG	Transplants

PROVIDER DATA

Date:	___ / ___ / ___	Name of Provider/Group:			
Rendering Physician Provider Type:					
Billing NPI Number: *(If applicable – Must be 10 digits)*					
Contracting Status:	PPO ☐	Non-Par ☐	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 ☐	Outpatient ☐	Inpatient ☐	Home ☐
Evaluation/Health History ☐		Office/Therapy Notes ☐		
CPT Procedure code(s):		ICD9 Diagnosis code(s):		
		☐ Left	☐ Right	☐ Bilateral ☐ NA

Other: