BlueCross BlueShield of Oklahoma

FOR INTERNAL USE ONLY
PRED
(Work Item Type)

Predetermination Request

THIS IS NOT AN APPEAL FORM AND CANNOT BE USED FOR VERIFICATION

Please allow up to 30 days for your request to be processed. This form only applies to members insured with Blue Cross and Blue Shield of Oklahoma. For status of your request please contact Provider Customer Service at (800) 496-5774.

Please attach supporting documentation to facilitate your request, for example, the history & physical, letter of medical necessity, original photographs, etc. For additional requirements, please see our medical policy.

This form must be placed on top of the information you are submitting.

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	Transplants
Breast MRI	Chemotherapy/Radiation	IMRT	
	E0935 CPM Device	PET Scan	

Mail to the Following Address or Fax to:

BCBSOK Members	P.O. Box 3283, Tulsa, OK 74102-3283 Fax: (312) 946-3541
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.
Federal Employee Program	P.O. Box 3283, Tulsa, OK 74102-3283 Fax: (888) 368-3406
BlueLincs HMO	P.O. Box 3283, Tulsa, OK 74102-3283 Fax: (918) 549-2358

Member/Patient Data:

Identification Number: *(Include the three-digit prefix)*		**Group #**	
Member's Name			
Patient's Name		**Anticipated Date of Service:**	
Patient's Date of Birth			
Procedure Codes: *(List primary first)*			
Diagnostic Codes: *(List primary first)*			

Please check one of the boxes: ☐ **Left** ☐ **Right** ☐ **Bilateral** ☐ **NA**

Place of Treatment *Please check one of the boxes:* ☐ **Provider Office** ☐ **Outpatient Facility** ☐ **Inpatient Facility** ☐ **Other**

Please include any additional information regarding the predetermination in the space below.

Provider Data:

National Provider Identifier (NPI) Number(s)		**Today's Date:**	
Physician/Professional Provider Name			
Address			

Contact Person		**Phone #**	( )	**Fax #**	( )