BlueCross BlueShield of Texas

FOR INTERNAL USE ONLY

PRE

(Work Item Type)

Predetermination Request

☐ ***URGENT***

(if checked, please provide anticipated date of service below)

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

Please attach supporting documentation to facilitate your request, for example, the history & physical, letter of medical necessity, original photographs, etc. This form must be placed on top of the information you are submitting.

Fax to 1.888.579.7935 *or* Mail to the Following Address:	
ParPlan/BlueChoice®	ParPlan/BlueChoice, P.O. Box 660044, Dallas, Texas 75266-0044
HealthSelect℠	HealthSelect, P.O. Box 660044, Dallas, Texas 75266-0044
Federal Employee Program	**THIS FORM DOES NOT APPLY TO FEP**
HMO Blue® Texas	HMO Blue Texas, P.O. Box 660044, Dallas, Texas 75266-0044

Member / Patient Data:		
Identification Number (Include the three-digit prefix)		**Group #**
Member's Name		
Patient's Name		**Anticipated Date of Service:**
Procedure Codes *(List primary first)*		
Diagnosis Codes *(List primary first)*		
Services Rendered	***Please check one of the boxes below:*** ☐ 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 # ( )**