BlueCross BlueShield of Texas

Instructions for submitting
REQUESTS FOR PREDETERMINATIONS

Predeterminations are not required.
We offer this service as a courtesy to our physician and other professional providers on behalf of our members.

1. ***Prepare a separate form for each individual request. Make sure all fields are completed.***
2. Compile **legible** copies of all the pertinent medical record documentation that will support the request for coverage of services.
   View the list of supporting documentation needed to successfully process a request.
   http://www.bcbstx.com/provider/pdf/medical_policy_guidelines_051410.pdf
3. Place each completed *Request for Predetermination Form* on ***top*** of the corresponding medical documentation being submitted.
4. Standard requests should be placed in a sealed envelope with the words "**REQUEST FOR PREDETERMINATION**" written on both sides and sent to the appropriate address found on the form.
5. Photographs will not be accepted over the fax. They should be placed in a sealed envelope with the words "**REQUEST FOR PREDETERMINATION – ORIGINAL PHOTOS – DO NOT BEND**" written on both sides and sent to the appropriate address found on the form.
6. To submit predeterminations for ***Synagis***, use the appropriate form found under https://www.bcbstx.com/provider/forms/index.html.
7. To be notified via fax of 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 made.

A Predetermination is not a guarantee of payment. It establishes medical necessity and determines if benefits would be available. All services are still subject to contract exclusions, pre-existing and claim check edits. For information concerning a guarantee of payment for services, please refer to http://www.bcbstx.com/provider/training/reference_guide.html for details.

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FOR INTERNAL USE ONLY
PRED
(Work Item Type)

Predetermination Request

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.

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

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

Fax to (888) 579-7935 *or* Mail to the Following Address:

ParPlan/Blue*Choice*®	ParPlan/Blue*Choice*, P.O. Box 660044, Dallas, Texas 75266-0044
HealthSelect℠	HealthSelect, P.O. Box 660044, Dallas, Texas 75266-0044
HMO Blue® Texas	HMO Blue Texas, P.O. Box 660044, Dallas, Texas 75266-0044
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.

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

Services Rendered — *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 #	( )