BlueCross BlueShield of Illinois

Predetermination Request Fax Form

Use this form to request:

1. A predetermination of benefits prior to rendering services.
2. An appeal of a previously denied predetermination of benefits.

Please include all required information, such as Provider information, Patient information and specific information for the services in question.

Please note: Inquires 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.

Fax the completed form to (800) 852-1360

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

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 ☐	E-mail Address:												
Contact First Name:			Contact Last Name:												
Telephone Number: ( ) -			Fax Number: ( ) -												
Street Address:															
City:	State:		Zip Code:												
Member Data:															
Member's Identification Number: (***Include alpha prefix***)															
Group Number:															
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):												
Other:															

Note: Please do not fax photographs. If additional information is required, i.e. photographs, we will request that you send them by mail.

All other requests, reviews, and standard written inquiries must be mailed to:
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112