Capital

MEDICARE ADVANTAGE PREDETERMINATION REQUEST— MEDICAL AND SURGICAL

Instructions for Submitting

Please complete this form when requesting predetermination of benefits for a specific procedure or service. If the determination will influence the decision to proceed with treatment, Capital Blue Cross recommends that nothing be scheduled until the final determination has been issued. A request for predetermination is not necessary for urgent or emergent medical treatment.

Predetermination requests are not required and are voluntary. They are performed as a courtesy review to determine if a proposed treatment or service is covered under a patient's health benefit plan. They do not take the place of any precertification requirements. Failure to obtain any necessary authorizations may result in a denial.

Please note that a service or treatment that has been predetermined for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon the member's eligibility at the time of the service, medical necessity, provider network status, applicable member copayments, coinsurance, deductibles, benefit plan exclusions, authorization referral requirements, and Capital Blue Cross medical policy.

It is important to read all instructions. This form cannot be utilized for verification of benefits or to request an appeal.

You will receive written notification once a determination has been made.

If you have any questions, please contact Capital Blue Cross Provider Services at 866.688.2242, Monday through Friday, 8 a.m. through 5 p.m. ET.

IMPORTANT PREDETERMINATION REMINDERS

1. Always verify eligibility and benefits first.
2. You are required to complete any other preservice requirements, such as Preauthorization, if applicable and required.
3. All applicable fields are required to be completed on the predetermination form. If all information is not provided, this may cause a delay in the predetermination process and may be returned for completion.
4. Fax information for each patient separately utilizing the fax number on the form.
5. Always place the Predetermination Request Form on top of other supporting documentation.
6. Do not send duplicate requests; this may delay the process.
7. Fax each completed Predetermination Request Form to 717.540.2171. If unable to fax, you may mail your request to:

Capital Blue Cross UM Department
PO Box 773731
Harrisburg, PA 17177-3731

Capital

MEDICARE ADVANTAGE PREDETERMINATION REQUEST FORM—
MEDICAL AND SURGICAL

Please fax completed form to Capital Blue Cross Predetermination at 717.540.2171.

Date Submitted: _____

Contact Name: _____ Contact Phone Number: _____

MEMBER INFORMATION

Member Name: _____ Member ID Number: _____

Date of Birth: _____ Male ☐ Female ☐

Diagnosis (ICD-10): _____

Requested Procedure(s), Service, or DME: _____

CPT or HCPC Code(s) (Required): _____

Anticipated Date of Service: _____

Place of Treatment: Provider Office ☐ Outpatient Facility ☐ Inpatient Facility ☐
Home ☐ Other ☐

Clinical information to support medical appropriateness, medications, presenting symptoms, plan of treatment, brief clinical history:

Please attach additional supporting documentation.

PROVIDER INFORMATION

Requesting Provider: _____

Provider ID: _____ NPI Number: _____

Telephone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Servicing Provider: _____

Provider ID: _____ NPI Number: _____

Telephone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

If provider/facility or supplier is out-of-network and requesting in-network benefits, please note that and provide the rationale for utilizing out-of-network services.

Capital Blue Cross medical policies can be accessed online at CapitalBlueCross.com.