of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

Predetermination Request Form
— Confidential —

Date Submitted:_____Pages attached (include cover and/or form):_____

Contact Name:_____Contact Phone #:_____Contact Fax #:_____

***** Please be sure contact fax number is clear due to HIPAA, since decision letters will be faxed to the provider.***

Please complete this form and submit with clinical when requesting predetermination of benefits for a specific procedure or service. If the determination of this review will influence the decision to proceed with treatment, BlueCross BlueShield of Tennessee recommends that nothing be scheduled until the final determination has been issued. A request for predetermination is not necessary for urgent or emergency medical treatment.

Predetermination requests are never required and are offered as a courtesy review to check for possible pre-existing conditions, benefits/coverage, and to ensure services meet medical criteria/guidelines. They do not take the place of any precertification/prior authorization requirements. Failure to obtain any necessary authorizations may result in a denial or reduction in benefits.

Member Name:	Member ID Number:
Date of Birth (mm/dd/yy):	☐ Male ☐ Female
Diagnosis (including ICD-9-CM Code):	
Procedure: ☐ Office ☐ Outpatient	
Regarding lab panel tests/or genetic panels: Are these codes part of a panel(s)? ☐ Yes ☐ No	
If part of a panel or panels – what is the name of the panel(s)?	

Requesting provider information below:

Requesting Provider:	Provider No.:	NPI No:
Telephone No.:	Fax No.:	
Address:	City:	State/Zip:

Requested Procedure(s) or Equipment:	**CPT® or HCPCS Codes (required):**

Codes continue on next page

Member Name:_____Date of Birth:_____Subscriber ID:_____

Additional codes not listed on page one:

Requested Procedure(s) or Equipment:	**CPT® or HCPCS Codes (required):**

BlueCross BlueShield of Tennessee Medical Policies can be accessed online: http://www.bcbst.com/providers/MPMSearch/search.asp.

Please return this completed form and any clinical for review to:

BlueCross BlueShield of Tennessee
Predetermination/ODM
1 Cameron Hill Circle, STE 0014
Chattanooga, TN 37402-0014

You may also fax this completed form to (423) 591-9091. If you have any questions, please contact BlueCross BlueShield of Tennessee Provider Service at 1-800-924-7141, Monday through Friday, 8 a.m. to 6 p.m. (ET).

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

Please note: Final reimbursement determinations are based on member eligibility at the time of service, Medical Necessity criteria, applicable member copayments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and BlueCross BlueShield of Tennessee Medical Policy. By submitting this request, you're confirming that you've provided all clinical information available pertinent to this request and you're requesting the decision be made based on information provided in your submission.

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