BlueCross BlueShield
Federal Employee Program

Federal Employee Program® and Postal Predetermination / Prior Approval Request Form

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 may be faxed to the provider.***

This form should not be used for Utilization Management requests such as Inpatient stays, Hospice care, Skilled Nursing stays, Residential Treatment stays, or Applied Behavior Analysis (ABA) therapy. Those requests should be sent to Utilization Management for review.

Please complete this form when requesting predetermination or prior approval for a specific procedure or service. Predetermination requests are never required and are offered as a courtesy review to check for benefits/coverage, and to ensure services meet medical criteria/guidelines. They do not take the place of any precertification/prior approval requirements. Failure to obtain any necessary authorizations may result in a denial or reduction in benefits. If the determination of this review will influence the decision to proceed with treatment, Federal Employee Program® (FEP)/Postal (PSHB) 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. (If a medical review is being requested, please allow up to 15 days for a determination to be made.)

Member Name:	Member ID Number:
Date of Birth (mm/dd/yy):	☐ Male ☐ Female
Diagnosis (including ICD-10 Code):	
Procedure: ☐ Office ☐ Outpatient ☐ Other	
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:

Codes on next page

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

Member Name:_____Date of Birth:_____Subscriber ID:_____

FEP/PSHB Medical Policies can be accessed online: https://www.fepblue.org/legal/policies-guidelines.

Please return this completed form 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 FEP Customer Service at 1-800-572-1003 or Postal Customer Service at 1-866-780-7742, 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 FEP/PSHB Medical Policy.