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

Predetermination Request Form

— Confidential —

Date Submitted: _____

Contact Name: _____ Contact phone #: _____

Please complete this form 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. (If a medical review is being requested, please allow up to 15 days for a determination to be made.)

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.

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 Provider Service at 1-800-924-7141, Monday through Friday, 8 a.m. to 5:15 p.m. (ET).

Member Name:	Member ID Number:
Date of Birth (mm/dd/yy):	☐ Male ☐ Female
Diagnosis (including ICD-9-CM Code):	

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

Clinical information to support medical appropriateness (e.g., failed outpatient therapy, laboratory or X-ray results, vital signs), **medications, presenting symptoms, plan of treatment and brief clinical history**:

Please attach additional supporting documentation (e.g., X-rays, pictures, Certificate of Medical Necessity)
☐ Attachment(s) ☐ No Attachment(s)

BlueCross BlueShield of Tennessee Medical Policies can be accessed online at www.bcbst.com.

Physician:	**Provider No.:**	**NPI No:**
Telephone No.:	**Fax No.:**	
Address:	**City:**	**State/Zip:**
Facility or Supplier:	**Provider No.:**	**NPI No.:**
Telephone No.:	**Fax No.:**	
Address:	**City:**	**State/Zip:**

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.