QualChoice® HEALTH INSURANCE

Predetermination Request Form
Instructions

A *predetermination* is a voluntary, written request by a provider to determine if a proposed treatment or service is covered under a patient's health benefit plan. Predetermination approvals and denials are based on our medical policies, coverage documents and benefits. View Medical Coverage Policies.

Please read all instructions before completing this form. This form cannot be used for verification of benefits or to request an appeal of non-certification determination.

The member and provider will receive written notification once a determination has been made.

REMINDERS

1. Always verify eligibility and benefits first.
2. All applicable fields of the request form are required. If information is not complete, there may be a delay in the predetermination process. Forms received without the member/patient's ID number, group number and date of birth cannot be processed and may be returned to you.
3. Always place the *Predetermination Request Form* on top of other supporting documents. Include any additional comments if needed.
4. Do not send duplicate requests, as this may delay the process.
5. If photos are required for review, mail photographs or email digital photos only along with the *Predetermination Request Form*. Please do not fax photographs. Faxed photos are not legible and cannot be used to make a determination.
6. Send a completed *Predetermination Request Form* for each patient by mail to the address below, or by fax to 844.501.2830 or by email to cm_benefit_inquiry@qualchoice.com.

Note: *The fact that a guideline is available for any given treatment or that a service or treatment has been preauthorized or predetermined for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based on, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date of service.*

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Today's Date (mm/dd/yyyy):	Scheduled/Anticipated Service Date (mm/dd/yyyy):

PROVIDER DATA

Primary Care Physician Information

Primary Care Physician NPI:	Primary Care Physician First Name:	Primary Care Physician Last Name:	
Contact First Name:	Contact Last Name:	Telephone Number:	Fax Number:
Street Address:	City:	State:	Zip:

Specialty Physician ☐ Network ☐ Out of Network

Specialty Physician NPI:		Specialty Physician Provider Type:		
Specialty Physician First Name:		Specialty Physician Last Name:		
Contact First Name:	Contact Last Name:	Telephone Number:	Fax Number:	
Street Address:		City:	State:	Zip:

Provider/Facility (Place of Service) ☐ Network ☐ Out of Network

Provider/Facility NPI:		Provider/Facility Type:		
Provider/Facility Name:				
Contact First Name:	Contact Last Name:	Telephone Number:	Fax Number:	
Street Address:		City:	State:	Zip:

MEMBER DATA

Member Identification Number:			
Group Number:			
Member's Legal First Name:	Member's Legal Last Name:	Telephone Number:	Email Address:
Patient's Legal First Name:	Patient's Legal Last Name:	Patient's Date of Birth (mm/dd/yyyy):	

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DOCUMENTATION

Attach documentation that supports or facilitates your request. The following information is required for review. Check all that apply.

Place of Treatment:

☐ Provider Office ☐ Outpatient Facility ☐ Inpatient Facility ☐ Home Office ☐ Other _____

☐ Evaluation/Health History ☐ Office/Therapy Notes

Diagnosis and Procedure, Services or Supplies to be Performed or Provided

Diagnosis Code (ICD10)	Narrative Description	Date of Service (mm//dd/yyyy)

Procedure Code (CPT)	Narrative Description	Date of Service (mm/dd/yyyy)

Fax to 844.501.2830 or email to cm_benefit_inquiry@qualchoice.com. Please do not fax photographs. If additional information is required, such as photographs, please mail photographs or send digital photos only by email.