BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

# PREDETERMINATION REQUEST COVER SHEET

Post Office Box 362025, Birmingham, AL 35236 • Fax 205-220-9560

**INSTRUCTIONS:** Please complete this form and attach as your cover sheet along with supporting documentation and clinical rationale for a predetermination review.

## I. Patient Information

| | |
|---|---|
| **Patient Name** (first/middle/last) | |
| Contract Number | Date of Birth |

## II. Treating Provider Information

| | | |
|---|---|---|
| Provider Name | Phone Number | Fax Number |
| Mailing Address | | |
| City | State | Zip |
| National Provider Identifier (NPI) | Tax ID Number | Provider ID Number |

## III. Medical, Surgical or DME Predetermination Information being Requested

☐ Inpatient
☐ Outpatient

☐ If this is an inpatient procedure include Facility name.

| CPT Code(s) | Diagnosis Code(s) | Right | Left | Bilateral | Additional Info: (Description for unlisted codes, lab test name and for vein procedures indicate the specific vein to be treated.) |
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