

Predetermination Request Form



Section 1 – Provider Information

Provider First Name	_____	Patient First Name	_____
Provider Last Name	_____	Patient Last Name	_____
Provider Address	_____	Patient Date of Birth	_____
City	_____	Patient ID Number	_____
State	ZIP Code	+4	Patient Group Number
Provider Phone Number	_____	Provider Fax Number	_____
Provider NPI	_____	ICD-10 Diagnosis Code(s) - separate with a comma	_____
Provider EIN	_____	CPT Codes(s) - separate with a comma	_____
Place of Service	_____	If you want the allowable/contractual obligation for the CPT code(s), please list your charges for each code:	_____

Section 2 – Additional Information

Please include history and physical and/or a brief narrative to include: symptoms, previous treatment, and any additional information as is appropriate. Attach additional sheets if necessary.

Section 3 – Please submit **photographs** for the following procedures to be performed

- | | |
|--|---------------------------------|
| Blepharoplasty (include visual fields) | Rhinoplasty |
| Scar revision | Breast reconstruction/reduction |
| Abdominoplasty (include height and weight) | Varicose vein procedures |

Section 4 – Home Medical Equipment Requests

For Home Medical Equipment requests, be sure to include a completed **Certificate of Medical Necessity (CMN) Form**.

Send this form with all necessary information to:

Blue Cross and Blue Shield of Kansas
Attention: Predetermination
P.O. Box 238, Topeka, KS 66601-1238
Fax: 785-290-0711
Email: csc@bcbsks.com

Your signature required

Preparer/Requestor _____ Date Signed _____

Print Name _____