

# Predetermination Request Form



Patient Name \_\_\_\_\_ Provider Name \_\_\_\_\_  
Patient ID Number \_\_\_\_\_ Provider Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
ICD-9 Diagnosis Code(s) \_\_\_\_\_  
CPT Code(s) \_\_\_\_\_

A. 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.)

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B. Please submit PHOTOGRAPHS for the following procedures to be performed:

- Blepharoplasty (include visual fields)
- Scar revision
- Abdominoplasty (include height and weight)
- Rhinoplasty

C. For Home Medical Equipment requests, be sure to include a COMPLETED Certificate of Medical Necessity (CMN) form.

D. Send this form with all other necessary information to:

Blue Cross and Blue Shield of Kansas  
Attention: PREDETERMINATION  
PO Box 238  
Topeka, Kansas 66601-0238  
Fax: 785-290-0711

Signature of Preparer/Requestor \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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