

# Predetermination Request Form



Section 1

Patient's Name \_\_\_\_\_ Provider Name \_\_\_\_\_  
Patient ID Number \_\_\_\_\_ Provider NPI \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Provider EIN \_\_\_\_\_  
Provider Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Provider Phone \_\_\_\_\_ Provider Fax \_\_\_\_\_  
ICD-9 Diagnosis Code(s) \_\_\_\_\_  
CPT Code(s) \_\_\_\_\_  
If you want the allowable/contractual obligation for the CPT code(s), please list your charges for each code below.  
Charges \_\_\_\_\_

Section 2

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.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sec. 3

Please submit **PHOTOGRAPHS** for the following procedures to be performed:  
Blepharoplasty (include visual fields)                      Abdominoplasty (include height and weight)  
Scar revision    Rhinoplasty

Sec. 4

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

Section 5

Send this form with all other necessary information to:  
Blue Cross and Blue Shield of Kansas  
Attention: PREDETERMINATION  
PO Box 238  
Topeka, Kansas 66601-1238  
Fax: 785-290-0711

Print Name of Preparer/Requestor \_\_\_\_\_

Signature of Preparer/Requestor

Date \_\_\_\_\_