Predetermination Request Form

(Pre-Service Request)

BlueCross BlueShield Kansas

This form should be used when either requesting advance information on Blue Cross and Blue Shield of Kansas coverage of items or services or advance approval of covered items or services that **do not** require prior authorization by Blue Cross.

Section 1 – Provider Information

CLEAR DATA

Provider First Name

Provider Last Name

Provider Address

City

State ZIP Code +4

(_____) _____-_____ Provider Phone Number

(_____) _____-_____ Provider Fax Number

Provider NPI

Provider EIN

Place of Service

☐ Inpatient ☐ Outpatient

Patient First Name

Patient Last Name

_____ /_____ /_____ Patient Date of Birth

Patient ID Number

Patient Group Number

ICD-10 Diagnosis Code(s) - separate with a comma

CPT Codes(s) - separate with a comma

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)

Scar revision

Abdominoplasty (include height and weight)

Rhinoplasty

Breast reconstruction/reduction

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