Blue Advantage
A Medicare Approved PPO

Predetermination Request

Instructions: Complete this form and attach with clinical documentation to support medical necessity for a predetermination review.

Fax number: 205-220-0675

Section I: Requesting Physician Information

Physician First Name	Physician Last Name	
Physician Telephone Number ___ – ___ – ____	Physician National Provider Identifier (NPI)	Physician Tax ID
Street Address or P. O. Box		
City	State	Zip Code	Contact Person

Section II: Patient Information

Prefix	Contract Number (Copy from the member's identification card.)	Patient Date of Birth (mm/dd/yyyy) ___ – ___ – ____
Patient First Name	Patient Last Name	

Section III: Required Documentation

☐ Inpatient
☐ Outpatient
☐ If this is inpatient procedure include facility name. _____

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

GRP20601-2606