Commercial Predetermination Request

Please type/print legibly. Submit completed form via Fax to:

423-591-9091

Or Mail to:

BlueCross BlueShield of Tennessee
Predetermination/ODM
1 Cameron Hill Circle, STE 0014
Chattanooga, TN 37402-0014

If you have any questions, please contact BlueCross BlueShield of Tennessee Provider Service at 1-800-924-7141, Monday through Friday, 8 a.m. to 5:15 p.m. (ET).

Please complete this form when requesting predetermination of benefits for a specific procedure or service. If the determination of this review will influence the decision to proceed with treatment, BlueCross BlueShield of Tennessee recommends that nothing be scheduled until the final determination has been issued. A request for predetermination is not necessary for urgent or emergency medical treatment. (If a medical review is being requested, please allow up to 15 days for a determination to be made.)

Predetermination requests are never required and are offered as a courtesy review to check for possible pre-existing conditions, benefits/coverage, and to ensure services meet medical criteria/guidelines. They do not take the place of any precertification/prior authorization requirements. Failure to obtain any necessary authorizations may result in a denial or reduction in benefits.

*BlueCross BlueShield of Tennessee Medical Policies can be accessed online at www.bcbst.com.

*Photos will not be returned, please do not send the original or only copy

Date Submitted
Member Name
Member Date of Birth
Member ID Number
Contact Name
Contact Phone and Fax Numbers
Diagnosis Name and Diagnosis Code
Physician Name
Physician Address
Physician #/Tax ID/NPI#

Physician Phone and Fax Numbers

Facility or Supplier Name

Facility or Supplier Address

Facility or Supplier #/Tax ID/NPI# (if services completed in Facility)

Facility or Supplier Phone and Fax Numbers

CPT or HCPCS Name and CPT or HCPCS Code

Rental/Purchase

Right Leg/Left Leg (if applicable)

Number if sessions (if applicable)

**Clinical Information**
Include a list of all pertinent information to support medical appropriateness, failed outpatient therapy, laboratory or X-ray results, vital signs, medications, presenting symptoms, plan of treatment and brief clinical history.

**Please attach additional supporting documentation**
X-rays, pictures, Certificate of Medical Necessity

**Please note:** Final reimbursement determinations are based on member eligibility at the time of service, Medical Necessity criteria, applicable member copayments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and BlueCross BlueShield of Tennessee Medical Policy.