



A Turn For The Better
Formerly MCA Administrators

Request for Predetermination

Fax completed form to: 412-202-5763 Note: To avoid delay in processing your request, please fill out this form completely. Photocopy and all Medical Records must be fax to 412-202-5763.

Physician or Provider Name _____

Physician or Provider Tax ID _____

Address _____

Contact Person Telephone _____ Email Address/Fax # _____

Name of Facility _____

Facility Address _____

Anticipated Date of Service ___ / ___ / ____ Outpatient Inpatient Observation Admission

Subscriber Name _____

Subscriber Number _____

Patient Name _____

Patient Date of Birth ___ / ___ / ____ Group/Policy Number _____

SERVICE DESCRIPTION

| Diagnosis Codes | CPT | HCPCS |
|-----------------|-----|-------|
| 1. | 1. | 1. |
| 2. | 2. | 2. |
| 3. | 3. | 3. |
| 4. | 4. | 4. |

Comments/Notes Describing the Service: _____

Is this a continuation of previous Approval: Yes ___ No ___ Buy and Bill cost _____.

Note: If the initial Pred is not Approved. Please fax any new documentation with this form for review. Examples include: • Test Results (lab, visual fields, radiology, sleep study, etc.) • Patient’s Current Condition • Pertinent History/Evaluation • Progress Notes-