90 DEGREE BENEFITS

A Turn For The Better

Request for Predetermination

Fax completed form to: 412-922-3071 Note: To avoid delay in processing your request, please fill out this form completely. Photocopy and all Medical Records must be fax to 412-922-3071.

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-