Predetermination Request Form

BlueCross BlueShield of Kansas

CLEAR DATA

Section 1 – Provider Information

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

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

An independent licensee of the Blue Cross Blue Shield Association.