



Pre-Determination Request Form (Medicare only)

FYI Review our provider manual criteria references. Submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of request.



Fax form and any relevant clinical documentation to: **612-884-2499** or **1-866-610-7215**.



For questions, call: **612-676-3300** or **1-888-531-1493**

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| PATIENT INFORMATION | Member Name _____ Member ID _____ Member Address _____ PMI _____ Member City, State, Zip _____ Date of Birth _____ Member Phone _____ Member Product _____ (required) |
| REQUIRED | Ordering Provider Name _____ ID/NPI Number _____ Ordering Provider Address _____ Ordering Provider City, State, Zip _____ Ordering Provider Phone _____ Fax _____ |
| SERVICE PROVIDER INFORMATION | Service Provider Contact Person _____ Service Provider Name _____ ID/NPI Number _____ *Service Provider Clinic Name _____ NPI Number _____ (required) Service Provider Address _____ Service Provider City, State, Zip _____ Service Provider Phone _____ Fax _____ Service Provider Email _____ |
| ADMINISTRATIVE INFORMATION | <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Standard Request Standard review timeframe for an authorization decision is within 14 calendar days or 10 business days from the date the request was received, as expeditiously as the member's health condition requires. </div> <div style="width: 45%;"> <input type="checkbox"/> Expedited Request Expedited review timeframe for urgent/emergent requests within 72 hours, as expeditiously as the member's health condition requires. Only request an expedited review if waiting the standard review timeframe would potentially jeopardize the member's health, life or ability to regain function. </div> </div> Physician/Staff Name _____ Date _____ Physician/Staff Signature _____ Phone _____ Request sent by _____ Total Pages Faxed _____ |

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| SERVICE PROCEDURE/ ITEMS REQUESTED | <p>Reason for pre-determination request (select one):</p> <p><input type="checkbox"/> Service/Procedure does not meet Original Medicare Medical Necessity Criteria</p> <p><input type="checkbox"/> Service/Procedure is not covered by Original Medicare</p> <p>Procedure code(s) HCPCS or CPT: _____</p> <p>Description of request</p> <p>_____</p> <p>_____</p> <p>Relevant ICD10 code(s) _____</p> <p>Diagnosis Description (include all) relevant to this request</p> <p>_____</p> <p>_____</p> <p>Number of Units/Visits Requested _____ Frequency (if applicable) _____</p> <p>Start Date Requested _____ (mm/dd/yy) (required)</p> <p>End Date Requested _____ (mm/dd/yy)</p> <p>Place of Residence</p> |
| CRITERIA | <p>Confirm and complete the required steps to proceed:</p> <p><input type="checkbox"/> Clinical notes supporting any of the above have been included in the submitted information.</p> |

Notes: Please allow 14 calendar days for decision. **Submission of all relevant clinical information with the request will reduce the number of days for the decision.**