Three Rivers Medical Management

Pre-Determination Request

FAX to 260-479-3568 **PHONE 888-773-0038 (toll-free) 260-479-3560 (local)**

*****Please attach pertinent clinical information on all Predetermination Requests- UPON RECEIPT OF *ALL* CLINICAL INFORMATION, DECISION WILL BE MADE WITHIN 15(FIFTEEN) BUSINESS DAYS.**

Request Date_____

Patient Name_____ Date of Birth _____

Address_____ Phone _____

_____

Employer _____Group# _____ Primary Insurance YES____ NO_____

PPO Network _____

Subscriber Name_____ ID#_____

SERVICE LOCATION: ___ INPATIENT ___ OUTPATIENT ___ MD OFFICE ___ OTHER

Procedure(s)_____ CPT Code_____

_____ CPT Code_____

Other Service(s) _____HCPCS_____

Other Service(s) _____HCPCS_____

Diagnosis(s)_____ DX Code_____

_____ DX Code _____

Facility/Service Provider_____ Date of Service_____

Requesting Physician/Provider: _____

Please call_____ at _____# _____ext_____

Or fax authorization to #_____(FAX)

FOR BENEFITS/ELIGIBILITY CONTACT THE CLAIMS ADMINISTRATOR

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TRMM RESPONSE
Contact Claim Administrator_____

Authorization Not Needed_____ **by**_____ **date**_____

Please fax clinical information _____ **by**_____ **date**_____

DISCLAIMER: This determination is for medical necessity ONLY and does not verify eligibility and/or benefit coverage. Refer to Claims Administrator or Summary Plan Description

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