Three Rivers Medical Management

Pre-Determination Request

FAX to 260-479-3568 ALTERNATE FAX 260-459-2096 PHONE 888-773-0038 (toll-free)

*****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/HCPCS_____

_____ CPT/HCPCS_____

Other Service(s) _____CPT/HCPCS_____

Diagnosis(s)_____ 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: No Review Needed___ Covered Service___ Excluded Service____ Approved ___

Approved from_____ to _____ Denied/Letter To Follow_____ by_____ Date_____

Comments:_____

Fax clinical information _____ Contact Claim Administrator_____ 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