

medpartners 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

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