

medpartners Three Rivers Medical Management
Pre-Determination Request For CHS –Group 2001

FAX to 260-435-6941
Attention: Karen

PHONE 888-773-0038 (toll-free) 260-435-7831 (local)

Request Date _____

*******PLEASE ATTACH PERTINENT CLINICAL INFORMATION ON ALL PREDETERMINATION REQUESTS**

Patient Name _____ Date of Birth _____

Address _____ Phone _____

Employer : CHS GROUP HEALTH PLAN Group# 2001 Primary insurance YES ___ NO ___

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 _____ Date of Service _____

Requesting Physician/Provider: _____

Please call _____ at _____ # _____ ext _____

Or fax authorization to # _____ (FAX)

**FOR BENEFITS/ELIGIBILITY CONTACT MEDPARTNERS
ADMINISTRATIVE SERVICES 888-312-9744**

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TRMM RESPONSE

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.