Instructions for Submitting Requests for Predeterminations

Complete and return to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921

Fax: 763.852.5057
Email: servicehelp@meritain.com

Predeterminations typically are not required. A predetermination is a voluntary, written request by a provider to determine if a proposed treatment or service is covered under a patient's health benefit plan. Predetermination approvals and denials are usually based on generally accepted medical policy and standards of care.

IMPORTANT PREDETERMINATION REMINDERS

1. Always verify eligibility and benefits first.
2. You must also complete any other pre-service requirements, such as preauthorization, if applicable and required.
3. All applicable fields are required. If all information is not provided, this may cause a delay in the predetermination process. (Inquiries received without the member/patient's group number, ID number, and date of birth cannot be completed and may be returned to you to supply this information.)
4. Fax information for each patient separately, using the fax number indicated on the form.
5. Always place the Predetermination Request Form on top of other supporting documentation. Please include any additional comments if needed with supporting documentation.
7. Do not send in duplicate requests, as this may delay the process.
8. If photos are required for review, the photos should be mailed along with the Predetermination Request Form and not faxed. Faxed photos are not legible and cannot be used to make a determination.

This form cannot be used for verification of benefits or to request an appeal of noncertification determination.

Please note that the fact that a guideline is available for any given treatment or that a service or treatment has been preauthorized or predetermined for benefits, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and plan provisions in effect at the time the service is rendered.

PROVIDER INFORMATION	
REQUESTING PROVIDER	PROVIDER PHONE
PROVIDER ADDRESS	PROVIDER FAX
FACILITY NAME/ADDRESS	
FACILITY INFORMATION (IF DIFFERENT FROM ABOVE)	

MEMBER INFORMATION	
MEMBER NAME	MEMBER ID NUMBER
GROUP NAME/NUMBER	
PATIENT NAME	PATIENT DATE OF BIRTH

DOCUMENTATION

Attach any documentation that supports your request. Please include:

- Place of treatment
- History and physical
- Office notes
- Procedure codes
- Diagnosis codes