



Predetermination Request / Appeal Form

Customer Service Phone: 800-288-2078

Medical Review Fax: 312-906-8359

Medical Review Email: mrinquiry@alliedbenefit.com

Mail: Allied Benefit Systems, LLC

P.O. Box 211651

Eagan, MN 55121

Before Proceeding, Note the Following:

- Benefit reimbursement is subject to 1) the terms, conditions, and limitations of the Plan's Summary Plan Description ("SPD"), and 2) eligibility of the patient at the time the service is incurred.
- **Please be sure to comply with any other applicable pre-certification requirements as stated on the patient's health benefits card.** If needed, please contact Allied's customer service department for current benefits at the telephone number listed on the patient's health benefits card.
- Please complete the form and submit all required documentation. Failure to do so may result in delays in processing.

Please Complete and Remit Form Along with Required Documentation

**Asterisk denotes required field. Numeric fields do not require dashes.*

Request Information

Date Submitted

Request Type (check one)

☐

Standard Request

☐

Urgent Request

Subscriber Information

Subscriber First Name*

Subscriber Last Name*

Employer Group Number*

Employer/Group Name*

Subscriber ID*

Patient Information

Patient First Name*

Patient Last Name*

Relationship to Subscriber*

Provider Information

Requesting Physician Name

Tax ID Number

Street Address

City

State

Zip

Phone Number

Fax Number

Requestor Information

First Name

Last Name

Phone Number

Fax Number

Predetermination Review Information

Check One

☐

Initial Request

☐

Continuation

☐

Predetermination Appeal

Diagnosis

ICD-10

Procedure

CPT®/HCPCS

Please Provide the Following Documentation for Your Request:

All Requests:

- Current history and physical
- Signs and symptoms, including members complaint
- Diagnostic lab and imaging results
- Letter of medical necessity
- Procedure and diagnosis code
- Last 6 months of office notes, labs, and imaging results