PO Box 9201 Austin, TX 78766
Phone: 800-301-8457
Fax: 737-243-8858

PRE-DETERMINATION FORM

Please complete and submit all requested information - ONLY ONE REQUEST PER FORM
PROVIDER AND FACILITY MUST BE IN-NETWORK * For Benefits and Network Status, call Boon-Chapman at 800-301-8457

Following Must Be Included: Patient's History & Physical, Clinical/Medical Records pertinent to the request, and Previous Treatment (including medication, therapy with response to treatment, diagnostic testing performed with results)

Patient Information

Patient Full Name:
Patient DOB:
Patient Phone Number:

Male Female
Member ID:
Group Name:

Ordering Provider Information

Ordering Physician/Provider:
Tax ID:
Office Phone Number:
Office Fax Number:
Office Contact Person:
Street Address:
City:
State:
Zip Code:

Servicing Provider Information

Hospital/Facility/Specialist:
Tax ID:
Office Phone Number:
Office Fax Number:
Office Contact Person:
Street Address:
City:
State:
Zip Code:

If there is an adverse determination, would you like a PEER to PEER?
Yes No
Provider Name:
Phone Number:
Best Time to Contact:

Procedure Information

Diagnostic Testing
Inpatient/# of Days:
Outpatient

PT/# of Visits:
OT/# of Visits:
ST/# of Visits:

Home Health/# of Visits:
DME
Specialty Referral

Date(s) of Service:

ICD Code(s):

CPT/HCPS Code(s):

Confidential Health Information Enclosed

Health Care Information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient/member or under circumstances that do not require patient/member authorization. You, the recipient, are obligated to maintain the health care information in a safe, secure and confidential manner. Re-disclosure of the health care information transmitted without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.