Recommended Clinical Review (formerly Pred) Form Guidelines

This form is not appropriate for certifying inpatient stays or authorizing services already provided. For inpatient services, call the precertification number on the back of the member's health plan ID card. If services have already been provided and denied, call **1-855-313-8914**.

STEP	ACTION
1	**Verify eligibility and benefits** to make sure your patient is covered and if services are covered. Log onto www.bcbsmt.com and register to view benefits, claims, and eligibility information or call 1-800-447-7828.
2	**Review the corresponding Medical Policy** published at www.bcbsmt.com for applicable clinical criteria.
3	**Complete the Recommended Clinical Review Request form**. You must check the appropriate box and include medical necessity documentation.

Provider Participation Notice

Healthy Montana Kids (HMK) members are required to use HMK participating providers when seeking medical treatment and all providers involved with this procedure must be HMK participating providers. Call Blue Cross and Blue Shield of Montana at 1-800-447-7828 to enroll in the network prior to rendering services or to inquire about whether the provider to whom you are referring an HMK member is an enrolled HMK participating provider.

Recommended Clinical Review approves the medical necessity and appropriateness of the services requested. The determination for payment of claims is made when the claim is received. The claim is subject to the terms and limitations of the member's benefit plan, including applicable co-payments. Recommended Clinical Review is only honored if the member is enrolled in HMK at the time services are rendered. HMK participating providers accept the HMK allowable as payment in full as specified in the provider agreement. HMK participating providers agree to bill the HMK member only for applicable copayments and for non-covered services the HMK member has agreed to pay in writing in advance of receiving services.

BlueCross BlueShield of Montana

MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services

FOR INTERNAL USE ONLY
PRED
(Work Item Type)

Predetermination Request Form – Healthy Montana Kids

Fax: 855-610-5684, Attn: Recommended Clinical Review
Mail: Utilization Management Department, Blue Cross and Blue Shield of Montana, PO Box 660255, Dallas, TX, 75266-0255

To check the status of a Recommended Clinical Review, please call 855-699-9907

Standard ☐		Urgent Request (Cancer Related Treatment) ☐	
Today's Date:	/ /	Scheduled/Anticipated Service/Admission Date:	/ /

PROVIDER DATA

Submitter Information			
Submitting Provider:			
Contact First Name:		Contact Last Name:	
Telephone Number:			
Ordering Physician			
Ordering Physician: (Individual – Type 1 NPI)			
Ordering Physician First Name:		Ordering Physician Last Name:	
Contact First Name:		Contact Last Name:	
Telephone Number:		Fax Number:	
Street Address:			
City:		State:	Zip:
Rendering Provider/Facility			
Rendering Facility/Physician/Provider: (Organization–Type 2 NPI) (Must be 10 digits)			
Rendering Physician Provider Type:			
Rendering Provider/Facility/Treating Therapist Name:			
Contact First Name:		Contact Last Name:	
Telephone Number:		Fax Number:	
Street Address:			
City:		State:	Zip:

MEMBER DATA

Member Identification Number: (Include the 3-digit prefix)			
Group Number:		Patient's Date of Birth:	/ /
Member's First Name:		Member's Last Name:	
Patient's First Name:		Patient's Last Name:	

DOCUMENTATION:

Attach any documentation that supports or facilitates your review. The following information is required for review. Check all that apply.

Place of Treatment:	Provider Office ☐	Outpatient Facility ☐	Inpatient Facility ☐	Home ☐	Other ☐
Evaluation/Health History ☐	Office/Therapy Notes ☐	Diagnosis Codes:			
Drug Name(s):	Dose/Frequency/Duration:				
Procedure Code(s)/Units:	Left ☐	Right ☐	Bilateral ☐	N/A ☐	
Additional Procedure Code(s)/Units:					

Blue Cross and Blue Shield of Montana complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Montana does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Montana:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: o Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Montana has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

To request auxiliary aids and services, including materials in alternative formats, please call 1-877-233-7055.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-710-6984 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-710-6984 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-710-6984 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-710-6984 (TTY: 711)。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-710-6984 (TTY: 711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-710-6984 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-710-6984 (ATS: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-710-6984 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-710-6984 (TTY: 711) 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-710-6984 (رقم هاتف الصم والبكم: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-710-6984 (TTY: 711).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-855-710-6984 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-710-6984 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-710-6984 (телетайп: 711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-710-6984 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-710-6984 (TTY: 711).