

## Pre-Determination

Name of Requester: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_

Duration of rendered service: \_\_\_\_\_

Member Name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Tax ID: \_\_\_\_\_

Billing NPI: \_\_\_\_\_

Professional:

Diagnosis Code: \_\_\_\_\_

Place of Service: \_\_\_\_\_

Unit/Minute count if necessary for the service provided: \_\_\_\_\_

	Service Code	Modifier	Primary Diagnosis	Charged Amount
1				
2				
3				
4				
5				

\*If additional service codes are being requested, please complete an additional form.

Institutional:

Type of Bill: \_\_\_\_\_

Admit Diagnosis: \_\_\_\_\_

Unit/Minute count if necessary for the service provided: \_\_\_\_\_

Revenue Code: \_\_\_\_\_

**IMPORTANT NOTICE:** This determination does not guarantee benefits or payment of services. Please allow 30 days for this request to be completed. A letter will be generated with details once processed. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim. If you have questions about your benefits, please contact Avera Health Plans Customer Care team at 605-322-4545 or toll-free at 1-888-322-2115. This form is not all-inclusive of services requiring preauthorization. Refer to patient's Certificate of Coverage, Master Contract or Summary Plan Document for more information.

If you have questions, please contact Avera Health Plans Customer Care at 605-322-4545 or toll-free at 1-888-322-2115.

Fax this completed form to Avera Health Plans at 605-322-4540 or send secure email to [Service@AveraHealthPlans.com](mailto:Service@AveraHealthPlans.com).