



Three Rivers Medical Management PRECERT/PREDETERMINATION REQUEST

FAX to 260-479-3568 ALTERNATE FAX 260-459-2096 PHONE 888-773-0038 (toll-free)
Go to www.medpartnersonline.com to obtain additional forms

Request Date _____

Patient Name _____ Date of Birth _____

Address _____ Phone _____

PPO Network _____ Primary insurance YES ___ NO ___

Employer _____ Group# _____

Subscriber Name _____ ID# _____

SERVICE TYPE

Inpatient ___ Outpatient ___ MD Office ___ Therapy ___ DME ___ Home Health ___ Home Infusion ___

Procedure(s) _____ CPT Code _____

_____ CPT Code _____

_____ CPT Code _____

Diagnosis(s) _____ DX Code _____

Facility/Service Provider _____ Date of Service _____

Requesting Physician _____ Contact _____

FAX # _____ Phone # _____ ext _____

****PLEASE ATTACH PERTINENT CLINICAL INFORMATION ON ALL PRECERT/PREDETERMINATION REQUESTS****

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TRMM RESPONSE: No Review Needed ___ Covered Service ___ Excluded Service ___

Authorization # _____ Approved ___ Denied ___ Letter To Follow ___

Approved from _____ to _____ #UNITS _____ DAYS_VISITS_PROCEDURES

Criteria used _____ by _____ Date/Time Faxed _____

Service authorized _____

Comments: _____

Fax clinical information _____ Contact Claim Administrator _____ Date _____

DISCLAIMER: This determination is for medical necessity ONLY and does not verify eligibility and/or benefit coverage. Refer to Claims Administrator or Summary Plan Description

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