Group Plan Solutions
Benefit Administration
A Division of Pekin Insurance®

GROUP PLAN SOLUTIONS
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Phone: 888-301-0747 • Fax: 855-545-7156

REQUEST FOR PREDETERMINATION OF MEDICAL BENEFITS

PATIENT INFORMATION

Name: _____ D.O.B.: _____

Member ID: _____

PREAPPROVAL INFORMATION

Name: _____

Phone: _____ Fax: _____

Address: _____

Contracting Status: ☐ PPO (Network: _____) ☐ Non-Par

Name of Person Filing Request: _____

TREATMENT DETAILS

Date of Proposed Treatment: _____

Place of Treatment: _____

☐ Office ☐ Hospital Outpatient ☐ Hospital Inpatient

☐ Other (_____)

CPT Code (s) (include cost per procedure): _____

ICD9 Code(s): _____

Notes: _____

_____

_____

Please include all documented history, previous treatments, and lab and diagnostic testing results related to the condition; the proposed treatment plan; and any other related records. If treatment is the result of a referral, include the referring physician's name, address, and phone number.

All documentation that supports your request can be submitted in any of the following manners. Mark which format you will be using to submit the documentation.

☐ Fax Transmission - Fax 855-545-7165. Include a copy of this form for reference.

☐ Mail - Group Plan Solutions, 2505 Court Street, Pekin, Illinois 61558.