NEW YORK STATE | The Empire Plan

ATTN: Predeterminations
UnitedHealthcare Insurance Company of New York
505 Boices Lane
Kingston, NY 12401
FAX #: 1-845-336-7716

PREDETERMINATION REQUEST

Use this form to:

1. Verify how much UnitedHealthcare may reimburse when certain medical services are being considered *PRIOR TO RENDERING SERVICES*. This is known as a Predetermination. **A Physician completes this form on a patient's behalf.**
2. Request an appeal of a previously denied Predetermination Request (*also PRIOR TO RENDERING SERVICES*).

Do NOT use this form:

- If the services have already been rendered or item has already been dispensed.
- If patient needs Durable Medical Equipment, Home Private Duty, Visiting Nurse Services, Home Infusion services/supplies, Physical or Occupational Therapy, or Chiropractic Care, call 1-877-7NYSHIP (1-877-769-7447) *PRIOR TO RENDERING SERVICES.*
- For High Tech Radiological Services such as an MRI, MRA ,CAT or PET Scan, or Nuclear Medicine/Cardiology, call The Benefits Management Program for Prospective Procedure Review at 1-877-7NYSHIP (1-877-769-7447) PRIOR *TO RENDERING SERVICES*
- For ordinary (general) medical care/verification of coverage. Call 1-877-7NYSHIP (1-877-769-7447) with your general coverage questions.

Both the provider and the patient will be informed of the outcome of this request, which is valid, in most cases, for up to six months.

Member Information												
Insured's I.D. #:											**Policy Group #:**	**30500**
Insured's First Name:			**Insured's Last Name**									
Patient's First Name:			**Patient's Last Name**							**Date of Birth:**		

Rendering Physician /Other Health Care Provider Information																					
Name of Individual Provider:										**Provider Group/Association Name:**											
Business Address																					
Billing Tax I.D.#										**Phone**											**EXT.**

Services To Be Performed			
Detailed Description:	**CPT/ HCPCS Code(s):**	**Diagnosis:**	**Estimated Fee(s):**

Accident Information			
If the proposed service(s) is related to an accidental injury, please provide:			
Date of Injury:		**Place of Injury:**	

Location of Proposed Services	
___**OFFICE** ___**INPATIENT HOSPITAL*** ___**OUTPATIENT HOSPITAL*** ___**OTHER*** ***PLEASE SPECIFY:***	
***If inpatient hospital, outpatient hospital, or other, list facility name:**	

Medical Documentation Required For Review

- **For specific information requirements, physicians may refer to:**
  UHCprovider.com > Policies and Protocols > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans
- **Include high quality photographs when applicable.** Please don't fax photographs. If photos are necessary, please send them with the Predetermination form at **UHCprovider.com.**

Signature of the Physician or Supplier

I hereby attest that the statement below applies to this request, and that I, acting as the patient's designee both have their permission to and agree to release of any clinical information necessary to process this predetermination of benefits.

Signature:	**Date:**

INSURANCE FRAUDS PREVENTION ACT

The following statement is printed pursuant to Regulation 95 of the New York State Insurance Department. "Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.