ATTN: Empire Plan Predeterminations
UnitedHealthcare Insurance Company of New York
P.O Box 1600
Kingston, NY 12402
FAX #: 1-845-249-2932

PREDETERMINATION REQUEST

Use this form to:

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.*

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* ___Ambulatory Surgery Center* __ *Other*______________*

*** Facility Name / Facility ID:**

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.

Please note that payment will be based on the submitted claim and the actual health care services received, the guidelines and policies in place at the time of service, applicable state and/or federal mandates and/or regulations, and the patient's plan when the services are received. The information in our response does not guarantee payment or represent a treatment decision. Treatment decisions are made between the patient and their physician or health care professional. We reserve the right to request medical records, at the time the claim is received to verify services.