Instructions for Submitting Requests for Predeterminations

Meritain Health®
an aetna company

Complete and return to:
Meritain Health®
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 716.541.6735
Email: predetermination@meritain.com

Please note: sending anything other than a predetermination request will delay the review of your information.

IMPORTANT PREDETERMINATION REMINDERS
Please note: surgery should not be scheduled prior to determination of coverage.

1. Always verify eligibility and benefits first.
2. You must also complete any other pre-service requirements, such as preauthorization, if applicable and required.
3. All applicable fields are required. If all information is not provided, this may cause a delay in the predetermination process. (Inquiries received without the member/patient's group number, ID number, and date of birth cannot be completed and may be returned to you to supply this information.)
4. Fax information for each patient separately, using the fax number indicated on the form.
5. Always place the Predetermination Request Form on top of other supporting documentation. Please include any additional comments if needed with supporting documentation.
7. Do not send in duplicate requests, as this may delay the process.
8. If photos are required for review, the photos should be mailed along with the Predetermination Request Form and not faxed. Faxed photos are not legible and cannot be used to make a determination.

Please note that the fact that a guideline is available for any given treatment or that a service or treatment has been preauthorized or predetermined for benefits, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and plan provisions in effect at the time the service is rendered. **Please note: attach all clinical documentation to support medical necessity.**

PROVIDER INFORMATION		
REQUESTING PROVIDER		PROVIDER TAX ID NUMBER
PROVIDER PHONE	PROVIDER FAX	PROVIDER ADDRESS
FACILITY NAME/ADDRESS		
FACILITY INFORMATION (IF DIFFERENT FROM ABOVE)		

MEMBER INFORMATION	
MEMBER NAME	MEMBER ID NUMBER
GROUP NAME/NUMBER	
PATIENT NAME	PATIENT DATE OF BIRTH

REQUESTED SERVICES:
PROCEDURE CODE(S):
DIAGNOSIS CODE (S):
IN OR OUT PATIENT?

Bariatric Surgeries: please verify guidelines in your patient's plan or Aetna CPB 0157.