For Pre-Determinations: **Group No: _______** **Group Name: _____________________**

FAX: 317-284-7473

Please include the following information:

Date: _______________________

Requested By:	
Location:	
Phone number and extension:	
Fax number:	

Member ID#:	
Patient's name:	
Date of Birth:	

Ordering Physician's name	
Facility:	
Date of Service:	

Diagnosis or ICD 10 code(s)	
Procedure(s):	
CPT code(s):	

Please attach supporting clinical information including office notes, diagnostic test results, and previous treatment.