Wellstar Health Plan

REQUEST FOR PRE-DETERMINATION

Submission Date		
Patient Name		
Patient ID #		Group ID#
Patient Date of Birth		
Provider/Group Name		
Provider Street Address		
Provider City/State/Zip		
Provider PPO Status	☐ PPO ☐ Non-PPO	
Submitter's Name		
Submitter's Phone #		
Submitter's Fax #		
Name of Treatment Location		
Procedure/Service Codes & Description		
Diagnosis Code & Description		
Place of Service		
Proposed Date ofService		
Medications (including pre-treatment)		
Comments		

Pre-determinations are not a requirement of the health plan. A pre-determination is offered as a courtesy to provide helpful information and does not guarantee benefits or payment.

For services that require pre-certification (prior authorization), refer to the Plan Booklet or ID card.

Please submit completed form and appropriate clinical information to one of the following:

Fax (no photographs): (586) 416-3001

Email (with color photographs): HBPRED@luminarehealth.com

Mail: Wellstar Health Plan
PO Box 4187, Clinton, IA 52733-4187

Wellstar Health Plan

Questions?

If you have any questions please contact our customer service department at the number listed on the member's ID card.

*** Please DO NOT send this page back with the Predetermination Form. ***

CHECK LIST:

- In an effort to complete the review as quickly as possible, be sure that you are submitting all necessary information.
- If none of the below apply, please disregard this page and send us the Predetermination Form with records.

Chemotherapy and/or Radiation Therapy:

- ☐ Full and complete treatment plan for each therapy the member will have. (chemo, radiation, or both)

Blepharoplasty:

- ☐ Documentation of visual field test – both taped and not taped.
- ☐ Color Photographs

Vein Surgery:

- ☐ Doppler or duplex ultrasound scanning with junctional reflux duration and vein size done within last 6 months
- ☐ All conservative treatments tried and failed (for Varicose Vein Surgery)
- ☐ Color Photographs

Botox:

(For Migraines, add below information, for all other diagnosis send medical records and Predetermination Form.)

- ☐ How many headaches is patient experiencing per month
- ☐ How many headaches per month are over 4 hours a day or longer?
- ☐ Please advise what preventative medications have been tried and failed?

Breast Reduction:

- ☐ Color Photographs
- ☐ How many grams of tissue will be removed per breast?

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