Beyond the expected.®
PEKIN™
INSURANCE

REQUEST FOR PREDETERMINATION OF MEDICAL BENEFITS

PATIENT INFORMATION

Name: D.O.B.:

Member ID:

PROVIDER INFORMATION

Name:

Phone: Fax:

Address:

Contracting Status: ☐ PPO (Network:) ☐ Non-Par

Name of Person Filing Request:

TREATMENT DETAILS

Date of Proposed Treatment:

Place of Treatment:

☐ Office ☐ Hospital Outpatient ☐ Hospital Inpatient

☐ Other ( )

CPT Code(s) (include cost per procedure):

ICD9 Code(s):

Notes:

Please include all documented history, previous treatments, and lab and diagnostic testing results related to the condition; the proposed treatment plan; and any other related records. If treatment is the result of a referral, include the referring physician's name, address, and phone number.

All documentation that supports your request can be submitted in any of the following manners. Mark which format you will be using to submit the documentation.

☐ Electronic Upload - After submission of this form, the confirmation page that follows will allow you to securely upload your records to our office. (Must be submitted in a PDF format.)

☐ Fax Transmission - Fax to 309-346-8265. Include a copy of this form for reference.

☐ Mail - Pekin Life Insurance Company, Attn: Health Claims, PO Box 129, Pekin, Illinois 61554. Include a copy of this form for reference.

Submit to Pekin Life Insurance Company