Prior Authorization Form
Please fax to: (952) 853-8713 For questions, call: (888) 467-0774

Procedures

Member information	
Member Name:	Member ID #:
DOB:	
Requester information	
Form completed by:	Clinic/facility:
Fax # for reply:	Phone #:
Provider information	
Procedural Physician: (last name)	(first name)
Tax ID #:	NPI #:
Fax #:	Phone #:
☐ **Facility/Clinic site for procedure or** ☐ **Lab information** ☐ **NA**	
Name:	Tax ID #:
Fax #:	Phone #:
Procedure information	
Place of service: ☐ Office or outpatient surgery ☐ Inpatient ☐ Home	
Proposed date of procedure: or ☐ TBD	
Primary diagnosis:	ICD-9/10:
Secondary Diagnosis:	ICD-9/10:
Procedure (CPT) Code:	Description:
Procedure (CPT) Code:	Description:
Procedure (CPT) Code:	Description:
Procedure (CPT) Code:	Description:
Procedure (CPT) Code:	Description:

Please check all that apply:

☐ Experimental or Investigational services, technologies, treatments or devices

Please explain:_____

☐ Non FDA approved procedure/device or treatment for this condition/diagnosis.

Please explain:_____

☐ An implant, graft and or a device is being inserted. Name of product: _____

☐ Cosmetic

☐ Other, please explain_____

Please submit any clinical documentation that supports your request