Bronchial Thermoplasty

Prior Authorization Form

Please Fax To (952)853-8713 For Questions Call (888) 467-0774

Member information	
Member Name:	Member ID #:
DOB:	
Requester information	
Form Completed By:	Clinic/Facility:
Fax #:	Phone #:
Billing Provider information	
Procedural Physician full name:	
NPI #:	Phone #:
Fax #:	
Billing Facility information	
Clinic/Facility Name:	Tax ID #:
Phone #	Fax #
Procedure information :	
Proposed date of procedure / / OR ☐ To Be Determined	
Primary Diagnosis: _____ ICD9 : _____ Other diagnoses: _____ ICD9: _____ _____ ICD9: _____	
Procedure (CPT) Code:	
Number of sessions requesting:	
Please submit supporting medical documentation that supports your request for this procedure.	

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