



Prior Authorization for Medical-Dental Procedures - Oral Surgery for Dental Conditions

Fax completed forms to (952)853-8713. Call Utilization Management (UM) at (952)883-6333 with questions. Incomplete forms will be returned. [Submit clinical documentation](#) to support your request.

Member information

First Name MI Last Name
HealthPartners ID # DOB

Requester information

Form completed by: First Name Last Name
Your business name
Your business street address
Your business city Your business state Your business zip
Phone* Fax**

Ordering physician information

Physician first name Physician last name
Specialty NPI
Clinic name
Clinic street address
Clinic city Clinic state Clinic zip
Clinic tax ID (claim may be rejected if incorrect)
Email Phone* Fax**

Procedural physician information

Physician first name Physician last name
Specialty NPI
Clinic name
Clinic street address
Clinic City Clinic state Clinic zip
Clinic tax ID (claim may be rejected if incorrect)
Email Phone* Fax**

Facility site for procedure or surgery

Facility name
Facility street address
Facility City Facility state Facility zip
Billing tax ID (claim may be rejected if incorrect)
Phone* Fax**

*Confidential voicemail required

**For outcome notification



Procedure or surgery

Only include codes requiring prior authorization; other codes will not be addressed.

Primary diagnosis code Description

Secondary diagnosis code Description

Procedure codes (s)

Procedure(s) or surgery description

Proposed date of procedure

Will waiting the standard review time seriously jeopardize member's health, life or ability to regain maximum functioning? yes no

Clinical reason for urgency (not scheduling issues)