HealthPartners®

# Prior Authorization for Medical-Dental Procedures - Surgical Intervention for TMD

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*

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## 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) _____

**Radiographs and photos must be mailed with this request form to:**

HealthPartners
QUI Mailstop 21108T
PO Box 1309
Minneapolis, MN 55440-1309

**Or emailed securely with request form to:** MedicalPolicy@HealthPartners.com

**Radiographs/photos were mailed/emailed on:** _____

1. What previous non-surgical treatments were tried in the past? _____

_____

_____

2. Describe physical symptoms: _____

_____

_____