HealthPartners

Procedures Prior Authorization Form

- Please fax form to 952-853-8713.
- For questions call HealthPartners QUI department at 952-883-6333.
- Form must be submitted prior to scheduling.
- Incomplete submissions may result in delay of the decision.

Member Information	
Member name:	HealthPartners ID #:
DOB:	
Requester Information	
Form completed by:	Clinic/Facility:
Fax #:	Phone #:
Provider Information	
Procedural physician: (Last name)	(First name)
Billing Tax ID #:	NPI #:
Fax #:	Phone #:
Facility Site for Procedure or Surgery	
Name:	Tax ID #:
Fax #:	Phone #:
Place of service: ☐ Office ☐ Outpatient ☐ Inpatient	
Procedure Information	
Proposed date of procedure: or ☐ TBD	
Primary diagnosis/ ICD-10 code:	
Secondary Diagnosis/ ICD-10 code:	
CPT code(s): *note only codes that require prior authorization will be listed on the authorization	
Procedure Description:	
☐ Non FDA approved procedure/device/treatment Explain: _____ ☐ Implant/graft/device being used Product name: _____	
Please submit any clinical documentation that supports your request	