HealthPartners

**Prior Authorization Form**
Please fax to: (952) 853-8713  For questions, call (952) 883-6333

## Procedures

| **Member information** | |
|---|---|
| Member name: | HealthPartners 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: |
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Please check all that apply:

☐ Experimental or Investigational services, technologies, treatments or devices

Explain:_____

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

Explain:_____

☐ An implant, graft and or a device is being inserted: Name of product_____

☐ Cosmetic

☐ Other, explain_____

**Please submit any clinical documentation that supports your request.**