

**MEDICAL COVERAGE FOR  
DENTAL PROCEDURES  
PREAUTHORIZATION  
REQUEST FORM**



**A determination notice will be mailed to the requesting provider, facility, and patient.  
Please attach pertinent chart notes as appropriate.**

**Please note:**

- PacificSource responds to preauthorization requests within two working days.
- Requests received after 3:00 p.m. are processed the next working day.
- Incomplete requests will delay the preauthorization process.

**PATIENT INFORMATION**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Member #: \_\_\_\_\_ Group #: \_\_\_\_\_

**PROCEDURE INFORMATION**

CPT / HCPCS procedure codes: \_\_\_\_\_  
Description: \_\_\_\_\_  
Description: \_\_\_\_\_  
ICD-9 diagnosis codes: \_\_\_\_\_  
Description: \_\_\_\_\_  
Dates of service: \_\_\_\_\_ Is this a retrospective request? Yes No  
Length of stay (if applicable): \_\_\_\_\_ Assistant surgeon requested? Yes No

**PROVIDER INFORMATION**

Place of service or vendor name: \_\_\_\_\_  
City/State: \_\_\_\_\_ Phone: \_\_\_\_\_  
Ordering physician/provider: \_\_\_\_\_  
City/State: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referring physician required for **Prime plans**: \_\_\_\_\_  
City/State: \_\_\_\_\_ Phone: \_\_\_\_\_  
**Out-of-state providers please provide Tax ID Number:** \_\_\_\_\_

**CONTACT INFORMATION**

Contact person/clinic/provider: \_\_\_\_\_  
Date: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_