PREAUTHORIZATION REQUEST FORM: MEDICAL COVERAGE FOR DENTAL PROCEDURES

PacificSource HEALTH PLANS

Please fax completed form with chart notes to: 541.225.3625

A determination notice will be mailed and/or faxed to the requesting provider, facility, and patient.

- PacificSource responds to preauthorization requests within two (2) working days.
- Requests received after 3:00 p.m. are processed the next work day.
- **Incomplete information will delay the preauthorization process.**
- Please include pertinent chart notes to expedite this request.

REQUESTING PROVIDER CONTACT INFORMATION

Date: _____ Contact person: _____

Phone: _____ Extension: _____ Fax: _____

PATIENT INFORMATION

Last name: _____ First name: _____

DOB: _____ Member number: _____

PROCEDURE INFORMATION

CPT / CDT code and description: _____

CPT / CDT code and description: _____

CPT / CDT code and description: _____

Additional notes: _____

Diagnosis code and description: _____

Retrospective review? ☐ Yes ☐ No Dates of service: _____ ☐ To be scheduled

☐ Outpatient ☐ Office

PROVIDER INFORMATION

Ordering provider or surgeon: _____

Address: _____

City/State/Zip: _____ Tax ID: _____

Phone: _____ Fax: _____

Place of service: _____

Address: _____

City/State/Zip: _____ Tax ID: _____

Phone: _____ Fax: _____

Health Services Department
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