HealthPartners®

Prior Authorization for Medical-Dental Procedures - Orthognathic Surgery

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: _____

All orthognathic surgery requests must include the following documentation:

1. Medical history, physical examination, and x-ray documentation dated within the previous 24 months which address symptoms related to the orthognathic deformity
2. Description of specific anatomic deformity present
3. Lateral and anterior-posterior cephalometric radiographs (x-ray providing multiple views of the jaws and skull allowing for measurement of these structures)
4. Diagnostic quality (clear) photographs that fully demonstrate the dental occlusion
5. If at the time of review orthodontic treatment has already begun, initial pre-treatment records must be provided.