Dental – Prior Authorization Form

Download, complete, and fax to 425-918-5956.

Effective November 1, 2021, we're only accepting electronic (not handwritten) forms. Please check codes online to confirm if a review is required before submitting a prior authorization request.

IMPORTANT: For the fastest response, use our online tools at premera.com/wa/provider for the following requests:

- Patient eligibility
- Prior authorization code checks
- Prior authorization
- Status checks, even if faxed prior (for in-area providers only)

A screenshot (with date) of the information found online can be used for verification documentation in case of appeal.

For providers in Washington:

Get everything you need to know about Premera prior authorization at premera.com/wa/provider/utilization-review/about-prior-authorization/.

For providers outside of Washington:
Visit your local Blue plan's provider website or premera.com/wa/provider/outside-washington-alaska/.

Note: Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.

PRE-SERVICE/ PRIOR AUTHORIZATION REVIEW REQUEST FORM

Complete and Fax To Dental Review: 425-918-5956 (Typed faxes only)

PREMERA | BLUE CROSS

Request date:

MEMBER/PATIENT: _____ Date of birth: _____
Member ID: _____ Suffix: _____ Group #: _____

REQUESTING PROVIDER: _____
Address: _____
City/State/ZIP: _____
Phone: _____ Fax: _____
Contact person: _____
Tax ID (**required**):_____
NPI # (if available): _____

SERVICING PROVIDER: _____
Address: _____
City/State/ZIP: _____
Phone: _____ Fax: _____
Contact person: _____
Tax ID (**required**):_____
NPI # (if available): _____

REQUIRED: Complete all fields that apply for place of service.

FACILITY: _____
Address: _____
City/State/ZIP: _____
Tax ID (**required**):_____
NPI # (if available): _____
Phone: _____ Fax: _____

☐ Outpatient hospital ☐ Inpatient hospital
☐ Office ☐ Ambulatory surgical center
☐ Ongoing treatment
* For medical and psychiatric lower levels of care, use our Admission/Concurrent Review Fax Form.
Date scheduled: _____
Existing reference #: _____
Expiration date: _____

☐ **URGENT REQUEST**
PLEASE NOTE: Scheduling issues do not meet the definition of urgent.
Urgent requests must be signed and include supporting documentation from the provider's office, noting that standard timeframes for making a non-urgent determination could:

- Seriously jeopardize the life/health of the patient or the ability to regain maximum function, **or**
- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, **or**
- In the opinion of a provider with knowledge of the member's medical or behavioral condition, subject the patient to adverse health consequences without the requested care or treatment.

I attest that this request meets the urgent definition described above: MD signature: _____

CLINICAL INFORMATION required. Attach supporting medical records and include presenting symptoms and previous treatment.

Procedure code/CPT code:	**Modifier: (LT/RT/ NU/RR)**	**ICD diagnosis code:**

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