



525 S. Lake Ave. Suite 222

Duluth, Minnesota 55802

Fax: 218-727-7250

Date: _____

PRIOR AUTHORIZATION REQUEST
(Please complete all applicable information)

Provider: _____

Subscriber: _____

Provider Number: _____

Address: _____

Address: _____

_____ Zip: _____

_____ Zip: _____

Phone: _____

Phone: _____

Group #: _____

Fax: _____

Identification #: _____

Contact: _____

PATIENT INFORMATION

Patient: _____

Birth Date: _____

Specific Procedure Planned: _____

Diagnosis - ICD-9 Code: _____

CPT - 4 Code(s) to be used: _____

Please attach relevant medical documentation: _____

Signature of Provider