



Dental Services Authorization Form
Fax completed form to: 608-252-0863

Oral Surgery

Temporomandibular Joint Disease (TMJ)

Anesthesia & Facility

Accidental Injury

PATIENT DEMOGRAPHICS

Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION

Provider Name:		Phone #:
Street Address:		Fax #:
City:	State:	Zip Code:
Provider #:	Specialty:	

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION

Referred To:		Phone #
Street Address:		Fax #
City:	State:	Zip Code:
Specialty:		

REQUESTED DATE OF SERVICE	DIAGNOSIS/ICD CODE(S)	
	1.	3.
	2.	4.

PROCEDURE/CPT CODE	DESCRIPTION

ADDITIONAL INFORMATION

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Form Submitted By:

Name:	Phone:	Fax:
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The completed form can be faxed to: 608-252-0863 If you have any questions regarding the services or form, please contact our Customer Care Center at 866-514-4194 or review wellfirstbenefits.com Requests to non-plan providers must be approved prior to obtaining services.

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