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

Form Submitted By:		
Name:	Phone:	Fax:

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.