Dental Insurance Pre-Authorization Request Form

Patient Information

Patient Name

Date of Birth

Patient ID / Member #

Address

City

State

ZIP

Phone

Email

Insurance Information

Insurance Company

Group Number

Policy Number

Plan Type

Subscriber Name

Subscriber DOB

Provider Information

Provider Name

NPI #

Office Phone

Office Fax

Office Address

City

State

ZIP

Request Details

Procedure Code(s)

Proposed Date of Service

Description of Services

Rationale/Medical Necessity

Signature

Provider Signature

Date