



**PRE-SERVICE REQUEST**  
**Date:** \_\_\_\_\_

Mail form to: Health and Wellness Services P.O. Box 179; Duluth, Minnesota 55801-0179  
 Fax form to: 1-866-938-9754

Provider Information	
Serving Provider:	Ordering Provider:
NPI #:	NPI #:
Provider Number:	Provider Number:
Address:	Address:
Fax:	Fax:
Contact Name/Phone #:	Contact Name/Phone #:
Facility/Home Health Agency Name:	Facility/Home Health Agency ID #:

Patient Information	
Patient Name:	Subscriber/Enrollee:
DOB:	Group Number:
Address:	Identification Number:
	Phone #

Specific Procedure Planned: _____
Diagnosis code(s): _____
Procedure CPT-4 Code(s) to be used: _____
Service Dates: ____/____/____ to ____/____/____

**\*\*\*Please attach relevant medical documentation\*\*\***  
**\*\*\*For prompt processing of your request – please complete ALL fields\*\*\***