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53720

Prior Authorization Request for Repetitive, Scheduled Non-Emergent Ambulance Transports
Medicare Part B Fax/Mail Coversheet

(Fields with a red asterisk (*) are required.)

Complete ONE (1) coversheet for each individual request, attach supporting medical documentation, and fax to **855-815-3065** or mail to the address below.

Request Type*: SELECT FROM DROP DOWN

If you selected "resubmission", please provide previous UTN

If you selected "expedite", please explain why the normal time frame jeopardizes the life or health of the beneficiary. Medical documentation must also support the need for an expedited review.*

Number of transports requested (round trip = 2 transports)*

Start of 60-day period (mm/dd/yyyy)*

Procedure code(s)* Modifier 1 Modifier 2

Ambulance Supplier Information

Supplier Name*

Supplier NPI* Supplier PTAN

Supplier Address*

Supplier City, State Zip*

State where ambulance is garaged* SELECT FROM DROP DOWN

Beneficiary Information

Last Name* First Name*

Medicare Beneficiary Identifier*

Date of Birth (mm/dd/yyyy)*

Certifying Physician Information

Certifying Physician Name

Certifying Physician NPI Certifying Physician PTAN

Certifying Physician Address

Certifying Physician City, State, Zip

Requester/Contact Information

Fax number (if a decision letter by fax is requested)

Contact Name Contact Phone/Ext.

Requester Name* Requester Phone/Ext.*

Requester Signature* Date*

FIRST COAST SERVICE OPTIONS, INC.

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