53719

Please Do Not Copy

EXPEDITED

Prior Authorization Request Hospital Outpatient Procedures

Expedited Medicare Part A Fax/Mail Cover Sheet

Complete all fields; attach supporting medical documentation and fax to **855-815-3065** or mail to the applicable address/number provided at the bottom of the page. Complete **ONE (1)** Medicare Fax/ Mail Cover Sheet for each prior authorization request for which documentation is being submitted.

Required Information

Beneficiary Last Name:		Beneficiary First Name:			
Medicare ID:		Gender: ☐ Male ☐ Female		Date of Birth:	
Facility NPI:	Facility CCN/PTAN:	Facility Fax Number:			
Facility Name and Address:					
Physician NPI:	Physician PTAN:	Physician Fax Number:			
Physician Name and Address:					
Requestor Name:		Requestor Email Address:			
Requestor Phone Number:		Procedure Code	Modifier ☐RT ☐LT ☐50	Site(s)/Level(s)	Unit(s) of Service
Alternate Phone Number and/or Direct Extension:		Procedure Code	Modifier ☐RT ☐LT ☐50	Site(s)/Level(s)	Unit(s) of Service
Request Type: ☐ Initial ☐ Resubmission		Procedure Code	Modifier ☐RT ☐LT ☐50	Site(s)/Level(s)	Unit(s) of Service
Diagnosis Codes (esMD submission only):					
Anticipated Date of Service:		State (location) of Authorization:		Date Submitted:	
Comments (i.e. Previous Non-Affirm UTN, Change in Facility, Record updates for resubmission, etc.)					

FIRST COAST SERVICE OPTIONS, INC.

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