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Prior Authorization Request Hospital Outpatient Procedures 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.

Beneficiary Last Name		Beneficiary First Name	
MEDICARE ID	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	
Facility/Agency NPIs		CMS Certification Number	
Facility Name and Address			
Provider's NPI		Provider's CMS Certification Number	
Provider's Name and Address			
Requestor Name		Requestor Phone Number	
Requestor Fax Number/Email address		Procedure Code(s)	
Paired Code(s) for Botulinum Toxin Injections			
Diagnosis Codes (providers who submit using esMD must include diagnosis code(s)):			
Start Date of Authorization	State (location) of Authorization	Units of Service	
Request Completed by: <i>(please print and sign)</i>			Date

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P.O. Box 3033
Mechanicsburg, PA 17055
www.fcso.com

