



53718



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.

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.)				

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