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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

Required Information

Request Type* SELECT FROM DROP DOWN	If you selected "resubmission", please provide previous UTN	
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 DROPDOWN	

Beneficiary Information

Beneficiary Last Name*:	Beneficiary First Name*:
Medicare ID*:	Date of Birth*:

Certifying Physician Information

Physician Name:	Physician NPI:	Physician PTAN:
Physician Address:	Physician City, State Zip:	

Requester/Contact Information

Fax number (if a decision letter by fax is requested):	Email:
Contact Name:	Contact Phone/Ext.:
Requester Name*:	Requester Phone/Ext.*:
Requester Signature*:	Date*:

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