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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 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 Phone Number	
Requestor Email address		Procedure Code(s)	
Paired Code(s) for Botulinum Toxin Injections		Trial or Permanent Implant? (for code 63650 only)	
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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