13718

Please Do Not Copy

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Prior Authorization Request Hospital Outpatient Procedures
Medicare Part A Fax/Mail Cover Sheet

Complete all fields; attach supporting medical documentation and fax to **833-200-9268** 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 ❑ Male ❑ 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: *(please print and sign)*		Date

NOVITAS SOLUTIONS

P.O. Box 3702
Mechanicsburg, PA 17055-3717
www.novitas-solutions.com