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13601

Prior Authorization Request for Wasteful and Inappropriate Service Reduction (WISeR) Model Medicare Part A Fax/Mail Coversheet

Complete all fields; attach supporting medical documentation and fax to 833-316-0467 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. (Fields with a red asterisk (*) are required.)

Required Information

Request Type:* SELECT ONE	Submission Type:* SELECT ONE	If you selected "resubmission", please provide previous UTN:	
State of Authorization:* SELECT ONE	Anticipated Date of Service:	Place of Service:* SELECT ONE	Type of Bill:* SELECT ONE
Procedure code(s):*		Modifier:	Unit(s) of Service:*
Procedure code(s):		Modifier:	Unit(s) of Service:
Procedure code(s):		Modifier:	Unit(s) of Service:
Diagnosis Codes:*			

Facility Information

Facility Name:*	Facility NPI:*	Facility CCN:*
Facility Address Line 1:*	Facility Address Line 2:	
Facility City:*	Facility State:*	Facility Zip:*

Beneficiary Information

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

Ordering/Referring Physician Information

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

Requester Information

Requester Name:*	Requester Email:*	Requester Phone/Ext.:*	Requester Fax:*

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