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13701

Prior Authorization Request for Wasteful and Inappropriate Service Reduction (WISeR) Model Medicare Part B 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
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:*			

Rendering Provider (ASC/ Physician)

Rendering Provider Name:*	Rendering NPI:*	Rendering PTAN:*
Rendering Address Line 1:*	Rendering Address Line 2:	
Rendering City:*	Rendering State:*	Rendering 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:*

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

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