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national government SERVICES

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Fields with an asterisk (*) are required

Pages included

*Request Type (check one): Initial ☐ Resubmission ☐ Expedite ☐

If you selected "resubmission", please provide previous UTN:

If you selected "expedite", please explain why the normal time frame jeopardizes the life or health of the beneficiary. Medical documentation must also support the need for an expedited review.*

_____

_____

*Number of transports requested (round trip = 2 transports)

*Start of 60-day period (mm/dd/yyyy)

*Procedure code(s): A0426 ☐ A0428 ☐ Modifier 1: Modifier 2:

Ambulance Supplier Information

*Supplier Name:

*Supplier NPI: Supplier PTAN:

*Supplier Address:

*Supplier City: *Supplier State: *Supplier Zip:

*State where ambulance is garaged:

Beneficiary Information

*Last Name: *First Name:

*Medicare Beneficiary Identifier:

*Date of Birth (MM/DD/YYYY):

*Beneficiary Address:

Certifying Physician Information

*Certifying Physician Name:

*Certifying Physician NPI: *Certifying Physician PTAN:

*Certifying Physician Address:

*Certifying Physician City: State: Zip:

Requester/Contact Information

Fax number (if a decision letter by fax is requested):

Contact Name: Contact Phone/Ext.:

*Requester Name: *Requester Phone/Ext.:

Requester Email:

*Requester Signature: *Date:

J6 Fax: 717-565-3840 JK: 315-442-4178

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