national government SERVICES

A CMS Medicare Administrative Contractor
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Prior Authorization Request for Outpatient Services Coversheet: Cervical Fusion with Disc Removal

Please ensure each REQUIRED field is completed correctly. FAX to JK: 317-841-4530 or J6: 317-841-4528

Request Date:	Number of pages including coversheet:
Submission Type: ***REQUIRED***	
☐ Initial Request ☐ Resubmission: ***IF THIS REQUEST IS IN RESPONSE TO A NON-AFFIRM, THIS IS A RESUBMISSION***	
☐ Expedited Review with Rationale:	

Beneficiary Information (see Medicare card)

Last name - ***REQUIRED***	First - ***REQUIRED***	Male ☐ Female ☐	Medicare ID - ***REQUIRED***	Date of Birth
Address, City, State, Zip				

Hospital Outpatient Department Information
*** Decision letters will be faxed or mailed to the Hospital Outpatient Department.*

Hospital/Facility Name - ***REQUIRED***	NPI - ***REQUIRED***	PTAN - ***REQUIRED***
ATTN (outpatient contact) - ***REQUIRED***	OPD contact phone number - ***REQUIRED***	
Address, City, State, Zip - ***REQUIRED***		
Fax number:		

Physician Information

Physician Name	NPI - ***REQUIRED***
Address, City, State, Zip	

Requestor Information

Requestor Name ***REQUIRED***:	Phone Number ***REQUIRED***:
Requestor Email Address ***REQUIRED***:	
FAX number: (for faxed submission ***REQUIRED***)	

Requested Outpatient Services *Select Applicable Outpatient Services Eligible for Prior Auth REQUIRED*

Claim Type of Bill (TOB) Code ***REQUIRED***	Anticipated Dates of Service/Surgery

Cervical Fusion with Disc Removal - ***REQUIRED***

☐ 22551 # of Unit(s) _____

☐ 22552 # of Unit(s) _____

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES