



Request Date:

A CMS Medicare Administrative Contractor

Prior Authorization Request for Outpatient Services Coversheet

Botulinum Toxin Injections

Please ensure each REQUIRED field is completed correctly. Any missing information marked REQUIRED could result in case rejection.

Please provide <u>direct</u> phone numbers for clinical and support staff questions.

Number of pages including coversheet:

FAX to JK: 317-841-4530 or J6: 317-841-4528

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 Mailing Address, City, State, Zip - REQUIRED **Note: Each beneficiary receives a decision letter** Hospital Outpatient Department Information **Decision letters will be faxed or mailed to the Hospital Outpatient Department** Hospital/Facility Name - REQUIRED PTAN - REQUIRED ATTN (outpatient contact) - REQUIRED OPD contact phone number - REQUIRED Address, City, State, Zip - REQUIRED Physician Information Physician Name - REQUIRED Requestor Information Requestor Name - REQUIRED Requestor Information Requestor Famil Address - REQUIRED FAX number Requested Outpatient Services Select Applicable Botulinum Toxin Injection Paired Service* - REQUIRED 64612 JOSBS # of units							
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