

A CMS Medicare Administrative Contractor

**Prior Authorization Request for Outpatient Services Coversheet
Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (including
Lipectomy), Related Services**

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

Please provide direct phone numbers for clinical and support staff questions.

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

Request Date:	Number of pages including coversheet:
Submission Type - REQUIRED	
Initial Request	Resubmission: <i>IF THIS REQUEST IS IN RESPONSE TO A NON-AFFIRM, THIS IS A RESUBMISSION</i>
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 <i>**Note: Each beneficiary receives a decision letter**</i>				

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

Physician Information

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

Requestor Information

Requestor Name - REQUIRED	Phone Number - REQUIRED
Requestor Email Address - REQUIRED	
FAX number -	

Requested Outpatient Services

Select Applicable Panniculectomy Service(s) - REQUIRED		
15830	15847	15877