

A CMS Medicare Administrative Contractor

Prior Authorization Request for Outpatient Services Coversheet

Rhinoplasty 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

Beneficiary Information (see Medicare card)

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:	

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	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

Rhinoplasty and Related Services - REQUIRED	
<input type="checkbox"/> 20912 # of Unit(s) _____	<input type="checkbox"/> 21210 # of Unit(s) _____
<input type="checkbox"/> 30400 # of Unit(s) _____	<input type="checkbox"/> 30410 # of Unit(s) _____
<input type="checkbox"/> 30420 # of Unit(s) _____	<input type="checkbox"/> 30430 # of Unit(s) _____
<input type="checkbox"/> 30435 # of Unit(s) _____	<input type="checkbox"/> 30450 # of Unit(s) _____
<input type="checkbox"/> 30460 # of Unit(s) _____	<input type="checkbox"/> 30462 # of Unit(s) _____
<input type="checkbox"/> 30465 # of Unit(s) _____	<input type="checkbox"/> 30520 # of Unit(s) _____