national government SERVICES

MEDICARE

A CMS Medicare Administrative Contractor

Prior Authorization Request for Outpatient Services Coversheet
Vein Ablation and 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: *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*	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 Vein Ablation Service – *REQUIRED*

*****Please indicate laterality on the line below - R, L, or Bilateral*****

☐ 36473 _____ ☐ 36474 _____

☐ 36475 _____ ☐ 36476 _____

☐ 36478 _____ ☐ 36479 _____

☐ 36482 _____ ☐ 36483 _____

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES