national government SERVICES

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A CMS Medicare Administrative Contractor
https://www.NGSMedicare.com

Prior Authorization Request for Outpatient Department (OPD) Services Coversheet

Facet Joint Interventions

Please ensure each **REQUIRED** field is completed correctly. Any missing information marked REQUIRED could result in case rejection. FAX to JK: 317-841-4530 or J6: 317-841-4528

Request Date:	Number of pages including coversheet:
Submission Type -*REQUIRED* ☐ Initial Request ☐ Resubmission: A *REQUEST IN RESPONSE TO A NON-AFFIRM,* **Resubmissions must include all initially submitted documentation in addition to additional records requested.*	
☐ 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 OPD***

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*	Direct Phone Number - *REQUIRED*
Requestor Email Address - *REQUIRED*	
FAX number - (*REQUIRED* for faxed submissions)	

*Requested Outpatient Services (*Please indicate laterality (right/left/bilateral) of each CPT code and sequence)*

MBB/IA	Laterality	Sequence	MBB/IA	Laterality	Sequence	RFA	Laterality	Sequence
☐64490 ☐64491 ☐64492	☐_____ ☐_____ ☐_____	☐Initial ☐Confirmatory ☐Therapeutic	☐64493 ☐64494 ☐64495	☐_____ ☐_____ ☐_____	☐Initial ☐Confirmatory ☐Therapeutic	☐64633 ☐64634 ☐64635 ☐64636	☐_____ ☐_____ ☐_____ ☐_____	☐Initial ☐Subsequent