national government SERVICES

MEDICARE

A CMS Medicare Administrative Contractor

Prior Authorization Request for Outpatient Services
Coversheet Implanted Spinal Neurostimulators

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 Implanted Spinal Neurostimulator Service-
REQUIRED

63650 ☐ Temporary or ☐ Permanent

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES