national government SERVICES

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

Prior Authorization Request for Outpatient Services Coversheet: Blepharoplasty, Blepharoptosis Repair and Brow Ptosis Repair

Please ensure each REQUIRED field is completed correctly. FAX to JK: 317-841-4530 or J6: 317-841-4528

Request Date:	Number of pages including coversheet:
Submission Type: ***REQUIRED –*** ☐ Initial ☐ Resubmission: ***IF THIS REQUEST IS IN RESPONSE TO A NON-AFFIRM, THIS IS A RESUBMISSION*** Request	
☐ Expedited Review with Rationale:	

Beneficiary Information (see Medicare card)

Last name - ***REQUIRED***	First - ***REQUIRED***	Male ☐ Female ☐	Medicare ID - ***REQUIRED***	Date of Birth
Address, City, State, Zip				

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:		

Physician Information

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

Requestor Information

Requestor Name ***REQUIRED***:	Phone Number ***REQUIRED***:
Requestor Email Address ***REQUIRED***:	
FAX number: (for faxed submission ***REQUIRED***)	

Requested Outpatient Services *Select Applicable Outpatient Services Eligible for Prior Auth REQUIRED*

Claim Type of Bill (TOB) Code ***REQUIRED***	Anticipated Dates of Service/Surgery
Laterality	

Blepharoplasty, Eyelid Surgery, Brow Lift, Related Services - ***REQUIRED***

☑ **15820** # of Unit(s) _____	☐ **15821** # of Unit(s) _____
☑ **15822** # of Unit(s) _____	☐ **15823** # of Unit(s) _____
☐ **67900** # of Unit(s) _____	☐ **67901** # of Unit(s) _____
☐ **67902** # of Unit(s) _____	☐ **67903** # of Unit(s) _____
☐ **67904** # of Unit(s) _____	☐ **67906** # of Unit(s) _____
☐ **67908** # of Unit(s) _____	

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES