



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

## Prior Authorization Request for Repetitive, Scheduled Non-Emergent Ambulance Transports Medicare Part B Fax/Mail Coversheet

Fields with an asterisk (\*) are required

# Pages included				
*Request Type (check o	one): Initio	al Res	ubmission	Expedite
If you selected "resubm	nission", please p	rovide previous l	JTN:	
If you selected "expedit Medical documentatio		-		oardizes the life or health of the beneficiary. view.*
*Number of transports	requested (roun	d trip = 2 transpo	orts)	
*Start of 60-day period	l (mm/dd/yyyy)			
*Procedure code(s):	A0426	A0428	Modifier 1:	Modifier 2:
		Ambulance	Supplier Informa	ation
*Supplier Name:				
*Supplier NPI:	IPI:		Supplier PTAN:	
*Supplier Address:				
*Supplier City:	Supplier City: *Supplier State:		*Supplier Zip:	
*State where ambulan	ce is garaged:			
		Benefic	iary Information	
*Last Name:	*First Name:			
*Medicare Beneficiary	Identifier:			
*Date of Birth (MM/DD	/YYYY):			
*Beneficiary Address:				
		Certifying P	hysician Informa	ation
*Certifying Physician N	ame:			
*Certifying Physician NPI: *Certifying Physician PTAN:				PTAN:
*Certifying Physician A	ddress:			
*Certifying Physician Ci	ty:	Stat	e:	Zip:
		Requester/	Contact Informa	rtion
Fax number (if a decisi	on letter by fax i	s requested):		
Contact Name:			Contact Phone/Ext.:	
*Requester Name:			*Requester Phone/Ext.:	
Requester Email:				
*Requester Signature:			*Date:	
		J6 Fax: 717-565-	3840 JK: 315-	442-4178

Mail to: National Government Services, Inc. Attn: Medical Review PAR PO Box 7108 Indianapolis, IN 46207-7108