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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 one)*: Initial ☐ Resubmission ☐

If you selected "resubmission", please provide previous UTN:

Number of transports requested (round trip = 2 transports)*

*Start of 60-day period (mm/dd/yyyy)

*Procedure code(s): A0426 ☐ A0428 ☐ Modifier 1: Modifier 2:

Ambulance Supplier Information

*Supplier Name:

*Supplier NPI: Supplier PTAN:

*Supplier Address:

*Supplier City: *Supplier State: *Supplier Zip:

*State where ambulance is garaged:

Beneficiary Information

*Last Name: *First Name:

*Medicare Beneficiary Identifier:

*Date of Birth (MM/DD/YYYY):

*Beneficiary Address:

Certifying Physician Information

*Certifying Physician Name:

*Certifying Physician NPI: *Certifying Physician PTAN:

*Certifying Physician Address:

*Certifying Physician City: State: Zip:

Requester/Contact Information

Fax number (if a decision letter by fax is 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