national government SERVICES

MEDICARE

A CMS Medicare Administrative Contractor

Prior Authorization Request for Outpatient Services Coversheet

Blepharoplasty, Blepharoptosis and/or Brow Ptosis Repair

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 Blepharoplasty, Blepharoptosis and/or Brow Repair Service – ***REQUIRED***

Please indicate laterality on the line below - R, L, or Bilateral*

☐ **15820** _____	☐ **15821** _____	☐ **15822** _____
☐ **15823** _____	☐ **67900** _____	☐ **67901** _____
☐ **67902** _____	☐ **67903** _____	☐ **67904** _____
☐ **67906** _____	☐ **67908** _____	

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES