national government SERVICES

A CMS Medicare Administrative Contractor

MEDICARE

Prior Authorization Request for Outpatient Services Coversheet

Cervical Fusion with Disc Removal

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 **Cervical Fusion with Disc Removal Service – *REQUIRED***

Note: *22552 cannot be requested without 22551*

☐ **22551** # of Unit(s) _____

☐ **22552** # of Unit(s) _____

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES