national government SERVICES

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

Prior Authorization Request for Outpatient Services Coversheet

Cervical Fusion with Disc Removal Services

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: A *REQUEST IN RESPONSE TO A NON-AFFIRM,* **Resubmissions must include all initially submitted documentation in addition to additional records requested.*	
☐ 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: The beneficiary listed will receive 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*	Hospital Fax number:	
Address, City, State, Zip - *REQUIRED*		
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*	Requestor Email Address - *REQUIRED*
Requester phone number - *REQUIRED*	Requester FAX number:
Non-PHI passcode created by the requester that allows NGS staff to communicate via email without the use of PHI. - OPTIONAL	

Requested Outpatient Services - REQUIRED

*Note: *22552 cannot be requested without 22551*

☐ **22551** # of Unit(s) _____

☐ **22552*** # of Unit(s) _____