

Outpatient Prior Authorization Request

Facility Information

Name*

NPI*

PTAN*

Contract/Region

- 10211 - Part A Georgia
 10311 - Part A Tennessee
 10111 - Part A Alabama

Beneficiary Information

First Name*

Last Name*

Date of Birth*

 / /

Medicare ID*

Gender*

- Male
 Female

Operating Physician Information

First Name*

Last Name*

NPI*

PTAN*

Address*

 ,

Attending Physician Information

Same as Operating Physician

-or-

First Name*

Last Name*

NPI*

PTAN*

Address*

 ,

This form continues on page 2.

Outpatient Prior Authorization Request - Page 2

Request Details

This is a resubmission. If yes, please provide UTN below.

Primary Diagnosis Code*

Is this life threatening? If yes, please explain below.

Secondary Diagnosis Code*

Additional Diagnosis Code(s)

Procedure Codes - Please select all procedure codes for this request.

Rhinoplasty

- 20912 30435
 21210 30450
 30400 30460
 30410 30462
 30420 30465
 30430 30520

Botox

- 64612
 64615
 J0585
 J0586
 J0587
 J0588

Blepharoplasty

- 15820 67902
 15821 67903
 15822 67904
 15823 67906
 67900 67908
 67901 67911

Panniculectomy

- 15830
 15847
 15877

Vein Ablation

- 36473 36482
 36474 36483
 36475
 36476
 36478
 36479

Number of Units Requested *(Required for requests with J0585, J0586, J0587, or J0588 only)*

Requestor Information

Requestor Name*

Requestor Phone*

() - ext

Requestor is a representative of the...

- Hospital Outpatient Department
 Physician/NPP

Requestor Fax (only if faxed response is requested)

() -

Facility Fax (see note)

() -

Note: If the Requestor is a representative of the Operating or Attending Physician AND a faxed response is requested, the fax number for the Facility is required in addition to the Requestor's fax number.

Please send this form and all additional documentation to:

Mail

Palmetto GBA
Part A - Prior Authorization
PO BOX 100212
Columbia, SC 29202-3212

Fax

(803) 462-7313