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Prior Authorization Request for Repetitive, Scheduled Non-Emergent Ambulance Transports Medicare Part B Fax/Mail Coversheet

(Fields with a red asterisk (*) are required.) Expedite Request Type (check one)*: Initial Resubmission If you selected "resubmission", please provide previous UTN If you selected "expedite", please explain why the normal time frame jeopardizes the life or health of the beneficiary. Medical documentation must also support the need for an expedited review.* Number of transports requested (round trip = 2 transports)* Start of 60-day period (mm/dd/yyyy)* Procedure code(s)* Modifier 1 * Modifier 2 **Ambulance Supplier Information** Supplier Name* Supplier NPI* Supplier PTAN * Supplier Address* Supplier City, State Zip* State where ambulance is garaged* **Beneficiary Information** Last Name* First Name* Medicare Beneficiary Identifier * Date of Birth (mm/dd/yyyy)* **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 Signature*

Contact Phone/Ext. Requester Phone/Ext.* Date*

PA-RR-B-1000

Please send this form and all additional documentation to **Fax: (803) 462-2632** RRB RSNAT P.O. Box 17089 Augusta, GA 30903-0001 The document being transmitted contains, private, privileged and confidential information belonging to the sender and intended for use by the addressee only. If this transmission is received by anyone other than the addressee, please advise the sender immediately to arrange for the return of these documents. In such circumstances you are advised that you may not review, disclose, copy, distribute or take any other action in connection with the documents transmitted.