

PRIOR AUTHORIZATION REQUEST FOR DURABLE MEDICAL EQUIPMENT COVERSHEET

Request Date _____ Number of Pages (including coversheet) _____ HCPCS Code _____

SUBMISSION TYPE

Initial _____ Resubmission _____ Expedited Review _____

If an expedited review is requested please provide rationale

BENEFICIARY INFORMATION

Name _____ Medicare ID _____

Date of Birth _____ State of Residence _____

SUPPLIER INFORMATION

Name _____ NPI _____ PTAN _____

Phone _____ Address _____

Fax _____ Point of Contact _____

TREATING PRACTITIONER INFORMATION

Name _____ NPI _____

Phone _____ Address _____

Fax _____

DOCUMENTATION REQUIREMENTS

Power Mobility Devices: https://www.cgsmedicare.com/jb/mr/pmd_prior_auth.html

Group II Pressure Reducing Support Surfaces: <https://www.cgsmedicare.com/jb/mr/prsspa.html>

Lower Limb Prosthetics: https://www.cgsmedicare.com/jb/mr/llp_prior_auth.html

Orthotics: https://www.cgsmedicare.com/jb/mr/orth_prior_auth.html

DECISION LETTER REQUEST

Beneficiary Letter _____ Treating Practitioner _____

Must include decision letter request (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_Physician_Sample_Decision_Letter_Request.pdf) form with PAR submission.

Please submit forms via the myCGS web portal, esMD, fax, or mail.

Fax: 1.615.660.5992

Mail: CGS - JUR B DME Medical Review - Condition of Payment Program

PO Box 23110

Nashville, TN 37202-4890

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