JURISDICTION 15 PART A PRIOR AUTHORIZATION OPD: BLEPHAROPLASTY



All fields are REQUIRED unless otherwise noted. Incomplete or illegible handwritten requests will be returned. **Note:** Use of this request document will require submission via fax, mail, or the electronic submission of Medical Documentation (esMD). To save time, use the myCGS web portal to submit your request, upload your documentation electronically, track the status of your request, and receive a quicker response.

Request Type		UTN		
Expedited Reason		Only required for Resubmissions & Expedited Resubmissions. Enter the UTN of most recent submission.		
Note: Provide reason for expediting request Request Type is selected above.	if Expedited Initial or Expedited Resubmission			
Requested HCPCS (maximum of 4)	Primary Diagnosis Code			
	Type of Bill			
	Date of Service			

FACILITY INFORMATION

Fax Number		
Note: If submitting by fax, fax number is required. The fax number must be the fax number of the Hospital Outpatient Department. If submitting by mail or esMD, fax number is optional. If you want to also receive the decision		

Note: Facility information should be the Hospital Outpatient Department information.

BENEFICIARY INFORMATION (only one beneficiary per form)

Medicare ID

ATTENDING PHYSICIAN INFORMATION

Physician Name

NPI

Fax Number

Address

REQUESTOR INFORMATION

Requestor Name

Email

Date

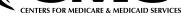
Phone Number

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Originated May 22, 2020 Revised August 22, 2023



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Please answer and follow the instructions for each question below.

QUESTIONS

Q1.	Does the beneficiary have any of the following functional indications?	Yes	or No
	Dermatocholasis		
	 Chronic dermatitis due to blepharochalasis from severe allergies or thyroid disease Interference with vision or visual field that impacts an activity of daily living (such as difficulty reading or driving), looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue 		
	 Significant/extreme difficulty fitting spectacles due to excessive eyelid tissue Debilitating eyelid irritation 		
	 Difficulty fitting or wearing a prosthesis when associated with an anophthalmic, microphthalmic, or enophthalmic socket. 		
	 Primary essential idiopathic blepharospasm that is debilitating for which all other treatments have failed or are contraindicated. Note: If answer is No, the procedure may not be considered medically necessary. 		
	Comments:		
Q2.	Are photographs and a physical examination present in the documentation submitted? Note: If answer is No, the procedure may not be considered medically necessary. Comments:	Yes	or No
		Nac	
Q3.	Does the medical record indicate the patient's desire for surgical correction?	Yes	or No
	Note: If answer is No, documentation may be insufficient to support medical necessity of the procedure.		
	Comments:		

Note: Attach supporting documentation for condition and associated symptoms, rationale for treatment procedure, etc. and/or comment..

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DOCUMENTATION

Condition and Associated Symptoms/ Rationale for Treatment Procedure