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JURISDICTION 15 PART A

PRIOR AUTHORIZATION OPD: RHINOPLASTY

PAR 253

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

Expedited Reason

Note: *Provide reason for expediting request if Expedited Initial or Expedited Resubmission Request Type is selected above.*

UTN

Only required for Resubmissions & Expedited Resubmissions. Enter the UTN of most recent submission.

Requested HCPCS (maximum of 4)

Primary Diagnosis Code

Type of Bill

Date of Service

FACILITY INFORMATION

Facility Name

PTAN

NPI

Region

Note: **Facility information should be the Hospital Outpatient Department 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 letter via fax, provide a fax number. A decision letter will be sent by mail to the provider address on file.*

BENEFICIARY INFORMATION (only one beneficiary per form)

Beneficiary Name

Medicare ID

ATTENDING PHYSICIAN INFORMATION

Physician Name

NPI

Fax Number

Address

REQUESTOR INFORMATION

Requestor Name

Email

Date

Phone Number

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Please answer and follow the instructions for each question below.

QUESTIONS

Q1. Does the beneficiary have a nasal deformity associated with congenital anomaly? **Yes** ☐ **No** ☐ **Not Applicable** ☐

Comments:

Q2. Does the beneficiary have a deformity resulting in breathing difficulty? **Yes** ☐ **No** ☐ **Not Applicable** ☐

Comments:

Note: If you have answered No to both questions, procedure may not be considered medically necessary.

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

DOCUMENTATION

Condition and Associated Symptoms/ Rationale for Treatment Procedure

