CGS ADMINISTRATORS, LLC | DME MAC JURISDICTION B

PRIOR AUTHORIZATION REQUEST FOR DURABLE MEDICAL EQUIPMENT COVERSHEET

Request Date **Number of Pages** (including coversheet) **HCPCS Code** **LT** ☐ **RT** ☐

Review Voluntary Accessory Code(s) ☐

Accessory HCPCS Code(s)

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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