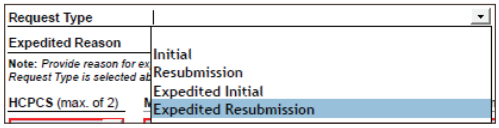
Repetitive Scheduled Non-Emergent Ambulance Transports

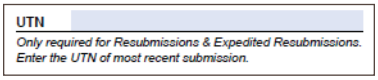
RSNAT Prior Authorization Request Form Instructions

The RSNAT prior authorization request form serves as a cover sheet for requesting a specified number of trips for a specified period of time. Ambulance suppliers can request up to 40 round trips (80 one way trips) for a 60-day period of time. The form needs to be completed in its entirety and submitted with the appropriate documentation. Typed forms are easier to read and can be processed faster versus handwritten forms.

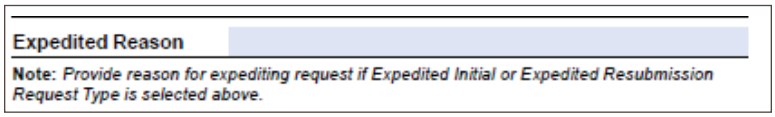
Instructions

1. Go to the CGS Medicare website (https://www.cgsmedicare.com), either J15 Part A or J15 Part B, and click on the Prior Authorization link located on the left hand side. Select Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT) link.
2. Locate the link for the RSNAT Prior Authorization Form and click on it. A new tab will open in the internet browser displaying the PDF form. The form can be typed on within the internet browser.
3. Select the type of request from the drop down menu. Initial request are submissions for services requested for the first time. A resubmission request are submissions submitted in the event a previous submission received a non-affirmed decision or a rejection. For resubmissions provide the UTN from the most recent submission.



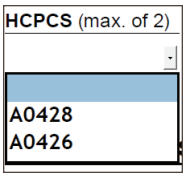


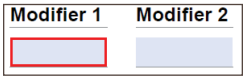
4. If it is an expedited request. Need to provide an explanation for the expedited request. An expedited request needs to include documentation indicating that any delays could jeopardize the health and well being of the beneficiary. Do **NOT** select expedited based on service dates alone. If does not meet criteria, leave blank.

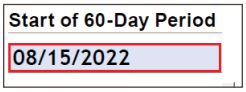


5. Select the HCPC code being requested for the prior authorization. There are only 2 to choose from: A0426 or A0428.
6. Include the modifier code for the transport which indicates to and from destinations.

   ** These modifiers will be attached to the UTN that is generated.*
7. Provide the start of 60-day period date. This needs to be an actual date of when services will begin. For example: 08/15/2022. **DO NOT** write "August 2022" or "whenever I get approval."

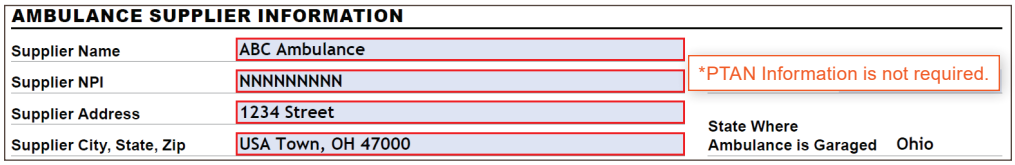




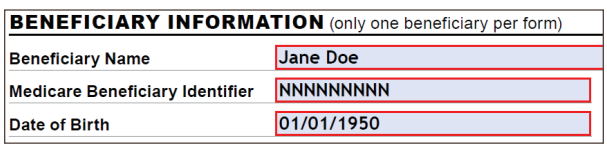


8. Type or clearly write in the number of transports being requested for the 60-day period. Maximum is 80 one-way trips in a 60-day period.

9. Type/clearly write all the ambulance supplier information in the appropriate fields.



10. Type/clearly write all the beneficiary information in the appropriate fields.



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11. Type/clearly write all the certifying physician information in the appropriate fields.

CERTIFYING PHYSICIAN INFORMATION

*PTAN Information is not required.

Certifying Physician Name	John Q. Physician		
Certifying Physician NPI	NNNNNNNN	Certifying Physician PTAN	NNNNNN
Certifying Physician Address	1234 Street, Ste A		
Certifying Physician City, State, Zip	USA Town, OH 47000		

12. Type/clearly write all the requestor information in the appropriate fields. Be sure to provide a working /valid fax number.

REQUESTOR INFORMATION

Requestor Name	John Doe		
Email	john.doe@email_address.com		
Date	07/18/2020	Fax number (if a decision letter by fax requested)	(123) 456-7890
Phone Number	(123) 456-7890		

13. Complete the questions located on pages 2 and 3. These questions provide guidance on documentation required for RSNAT transport. Any "No" responses may result in services not being considered reasonable and medically necessary. There are a total of 8 questions.

QUESTIONS

Q1. Is a Provider Certification Statement (PCS) present? Yes ○ or No ○

Note: If answer is No, the service may not be considered reasonable and necessary due to insufficient documentation.

Comments:

14. Print completed form by clicking on the print icon located in the internet browser. **DO NOT** download or save the form to a local computer or drive.

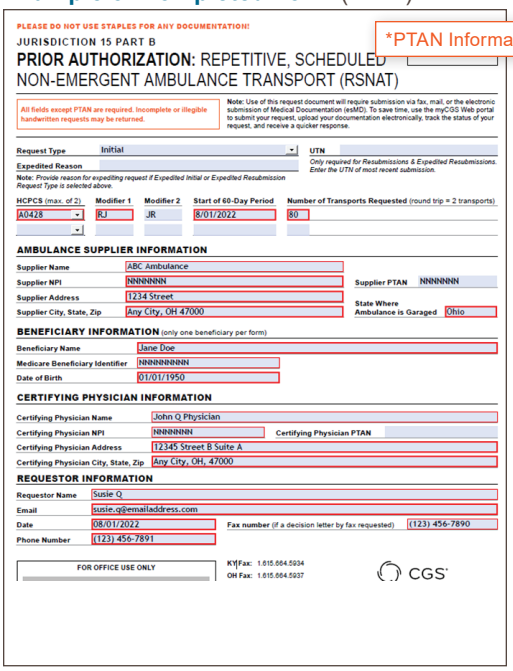
15. Submit the completed form along with all the appropriate documentation by fax, mail, or esMD.

KY Fax: 1.615.664.5934
OH Fax: 1.615.664.5937
Mail to: CGS
PO Box 20203
Nashville, TN 37202

myCGS

The RSNAT prior authorization request can be completed electronically through the myCGS portal. The form in the portal contains the same fields and can easily be completed and submitted. There is a space provided for ambulance suppliers to upload the required documentation before submitting the form via the portal.

Example of Completed Form (Initial)



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION!

JURISDICTION 15 PART B

PRIOR AUTHORIZATION: REPETITIVE, SCHEDULED NON-EMERGENT AMBULANCE TRANSPORT (RSNAT)

*PTAN Information is not required.

All fields except PTAN are required. Incomplete or illegible handwritten requests may 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: Initial
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.

HCPCS (max. of 2)	Modifier 1	Modifier 2	Start of 60-Day Period	Number of Transports Requested (round trip = 2 transports)
A0428	RJ	JR	8/01/2022	80

AMBULANCE SUPPLIER INFORMATION

Supplier Name	ABC Ambulance		
Supplier NPI	NNNNNNN	Supplier PTAN	NNNNNNN
Supplier Address	1234 Street		
Supplier City, State, Zip	Any City, OH 47000	State Where Ambulance is Garaged	Ohio

BENEFICIARY INFORMATION (only one beneficiary per form)

Beneficiary Name	Jane Doe
Medicare Beneficiary Identifier	NNNNNNNNN
Date of Birth	01/01/1950

CERTIFYING PHYSICIAN INFORMATION

Certifying Physician Name	John Q Physician		
Certifying Physician NPI	NNNNNNN	Certifying Physician PTAN	
Certifying Physician Address	12345 Street B Suite A		
Certifying Physician City, State, Zip	Any City, OH, 47000		

REQUESTOR INFORMATION

Requestor Name	Susie Q		
Email	susie.q@emailaddress.com		
Date	08/01/2022	Fax number (if a decision letter by fax requested)	(123) 456-7890
Phone Number	(123) 456-7891		

FOR OFFICE USE ONLY

KY Fax: 1.615.664.5934
OH Fax: 1.615.664.5937

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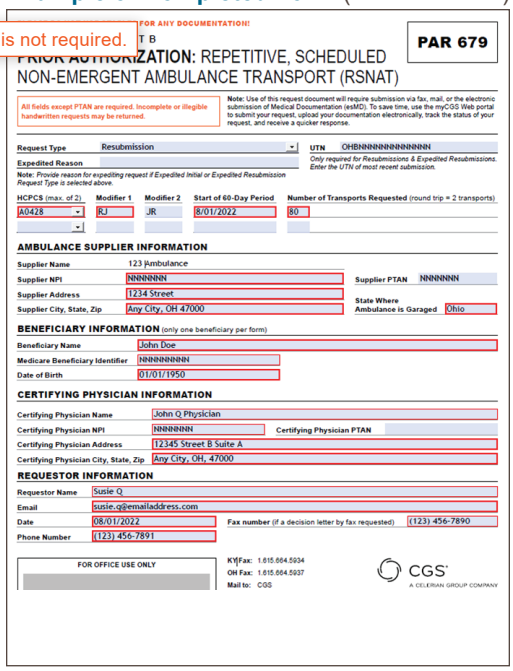
Example of Completed Form (Resubmission)



PAR 679

PRIOR AUTHORIZATION: REPETITIVE, SCHEDULED NON-EMERGENT AMBULANCE TRANSPORT (RSNAT)

All fields except PTAN are required. Incomplete or illegible handwritten requests may 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: Resubmission
Expedited Reason:
Note: Provide reason for expediting request if Expedited Initial or Expedited Resubmission Request Type is selected above.
UTN: OHBNNNNNNNNNNNNN
Only required for Resubmissions & Expedited Resubmissions. Enter the UTN of most recent submission.

HCPCS (max. of 2)	Modifier 1	Modifier 2	Start of 60-Day Period	Number of Transports Requested (round trip = 2 transports)
A0428	RJ	JR	8/01/2022	80

AMBULANCE SUPPLIER INFORMATION

Supplier Name	123 Ambulance		
Supplier NPI	NNNNNNN	Supplier PTAN	NNNNNNN
Supplier Address	1234 Street		
Supplier City, State, Zip	Any City, OH 47000	State Where Ambulance is Garaged	Ohio

BENEFICIARY INFORMATION (only one beneficiary per form)

Beneficiary Name	John Doe
Medicare Beneficiary Identifier	NNNNNNNNN
Date of Birth	01/01/1950

CERTIFYING PHYSICIAN INFORMATION

Certifying Physician Name	John Q Physician		
Certifying Physician NPI	NNNNNNN	Certifying Physician PTAN	
Certifying Physician Address	12345 Street B Suite A		
Certifying Physician City, State, Zip	Any City, OH, 47000		

REQUESTOR INFORMATION

Requestor Name	Susie Q		
Email	susie.q@emailaddress.com		
Date	08/01/2022	Fax number (if a decision letter by fax requested)	(123) 456-7890
Phone Number	(123) 456-7891		

FOR OFFICE USE ONLY

KY Fax: 1.615.664.5934
OH Fax: 1.615.664.5937
Mail to: CGS

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