

Prior Authorization Request (PAR) Coversheet

JURISDICTION C

Power Mobility Demonstration

Request Date _____
For HCPCS _____
Entity Submitting Supplier Physician/Treating Practitioner (TP) _____
Supplier Name _____
Supplier Address _____

Supplier Phone _____
Supplier Contact Name _____
Supplier Fax _____
Supplier NPI _____
Supplier NSC _____

Number of Pages (including coversheet) _____
Initial Request OR Subsequent Request _____

Physician/TP Name _____
Physician/TP Address _____

Physician/TP Phone _____
Physician/TP Fax _____
Physician/TP NPI _____

Beneficiary Name _____ Beneficiary HICN _____
Beneficiary State of Residence _____ Beneficiary Date of Birth _____

Expedited Request? Yes No

Note: Expedited requests require justification to meet expedited requirements.

Expedited Request Justification _____

Checklist of PAR information to include:

- Completed coversheet
- 7-element order
- Face-to-Face assessment
- Detailed product description
- Specialty evaluation (if required by policy)
- Other relevant medical documentation

Fax the PAR to: 1.615.664.5960

OR

Mail the PAR to: CGS
DME Medical Review - Prior Authorization
PO Box 24890
Nashville, TN 37202-4890

For additional information, such as the medical policy, please visit our website

at: http://www.cgsmedicare.com/jc/coverage/mr/power_mobility_resources.html

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