CGS ADMINISTRATORS, LLC | DME MAC JURISDICTION C

PRIOR AUTHORIZATION REQUEST FOR DURABLE MEDICAL EQUIPMENT COVERSHEET

Request Date _____ **Number of Pages** (incl. coversheet) _____ **HCPCS Code** _____ **LT** ☐ **RT** ☐

Review Voluntary Accessory Code(s) ☐

Accessory HCPCS Code(s) _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

SUBMISSION TYPE

Initial ☐ **Resubmission** ☐ **Expedited Review** ☐

Power mobility device replacement request for item lost, stolen or irreparably damaged please **select the **Expedited Review** box.

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/jc/pa/pmd.html
Group II Pressure Reducing Support Surfaces: https://www.cgsmedicare.com/jc/pa/prss.html
Lower Limb Prosthetics: https://www.cgsmedicare.com/jc/pa/llp.html
Orthotics: https://www.cgsmedicare.com/jc/pa/orthoses.html
Osteogenesis Stimulators: https://www.cgsmedicare.com/jc/pa/osteo.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: 1.615.664.5960
Mail: CGS - JUR C DME Medical Review - Condition of Payment Program
PO Box 24890
Nashville, TN 37202-4890

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