PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION!

JURISDICTION 15 PART A

PRIOR AUTHORIZATION OPD: BLEPHAROPLASTY

PAR 251

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.*

Requested HCPCS (maximum of 4)

UTN

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

Primary Diagnosis Code

Date of Service

Type of Bill

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

REQUESTOR INFORMATION

Requestor Name

Phone Number

Date

Email

FOR OFFICE USE ONLY

Fax to: 1.615.782.4486

Mail to: CGS
PO Box 20203
Nashville, TN 37202

For additional information, please visit our website at: https://www.cgsmedicare.com/parta/mr/opd.html

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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 any of the following functional indications? **Yes** ☐ **or No** ☐

- Dermatocholasis
- Chronic dermatitis due to blepharochalasis from severe allergies or thyroid disease
- Interference with vision or visual field that impacts an activity of daily living (such as difficulty reading or driving), looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue
- Significant/extreme difficulty fitting spectacles due to excessive eyelid tissue
- Debilitating eyelid irritation
- Difficulty fitting or wearing a prosthesis when associated with an anophthalmic, microphthalmic, or enophthalmic socket.
- Primary essential idiopathic blepharospasm that is debilitating for which all other treatments have failed or are contraindicated.

Note: If answer is No, the procedure may not be considered medically necessary.

Comments:

Q2. Are photographs and a physical examination present in the documentation submitted? **Yes** ☐ **or No** ☐

Note: If answer is No, the procedure may not be considered medically necessary.

Comments:

Q3. Does the medical record indicate the patient's desire for surgical correction? **Yes** ☐ **or No** ☐

Note: If answer is No, documentation may be insufficient to support medical necessity of the procedure.

Comments:

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

