PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION!

JURISDICTION 15 PART B OHIO

PRIOR AUTHORIZATION ASC: BOTULINUM TOXIN INJECTION

PAR 805

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 CPTs/HCPCS (max of 4)

Note: *A minimum of 2 codes indicating the services requested is required for submission of this request (for example, 64612 requires a corresponding J code).*

UTN

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

Primary Diagnosis Code

Date of Service

Number of Units

ASC INFORMATION

ASC Name

PTAN

NPI

Region

Fax Number

Note: **If submitting by fax, fax number is required.**
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

PERFORMING SURGEON INFORMATION

Surgeon Name

NPI

Fax Number

Address

REQUESTOR INFORMATION

Requestor Name

Phone Number

Date

Email

FOR OFFICE USE ONLY

For Ohio, fax to: 615.782.4663

Mail to: CGS
PO Box 20203
Nashville, TN 37202

For additional information, please visit our website at: https://cgsmedicare.com/partb/pa/asc.html

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Originated October 3, 2025

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Please answer and follow the instructions for each question below.

QUESTIONS

Q1. Is the botulinum toxin being used for medical indication (not cosmetic) and treatment with botulinum toxin is considered medically acceptable treatment for this condition? **Yes** ☐ **or No** ☐

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

Comments:

Q2. Does the beneficiary have one or more of the following diagnoses? **Yes** ☐ **or No** ☐

- Dystonia/Spasticity
- Blepharospasm, Hemifacial Spasms, Strabismus
- Headache/Migraine

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

Comments:

Q3. Is there detailed documentation of symptoms and/or progression of the illness? **Yes** ☐ **or No** ☐

TASK: *If "Yes," attach supporting documentation and notes.*

Comments:

Q4. Is there documented history of failed/conservative treatment measures? **Yes** ☐ **or No** ☐

TASK: *If "Yes," attach supporting documentation and notes.*

Comments:

Note: Attach supporting documentation for condition and associated symptoms, rationale for treatment procedure, etc. and/or comment.

Q3 DOCUMENTATION

Symptoms or Progression of Illness

Q4 DOCUMENTATION

History of Failed/Conservative Treatment Measures

