PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION!

JURISDICTION 15 PART B OHIO

PRIOR AUTHORIZATION ASC: RHINOPLASTY

PAR 803

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.*

UTN

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

Requested CPTs (maximum of 4)

Primary Diagnosis Code

Date of Service

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

Email

Date

Phone Number

Disclaimer: The documents accompanying this facsimile transmittal are intended only for the use of the individual or entity to which it is addressed. It contains information that is privileged, confidential, and exempt from disclosure under law. If the recipient of this document is not the intended recipient, you are notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you are not the intended recipient, you are hereby notified that by law you are strictly prohibited to disclose, copy, distribute, or take any action in reliance on the contents of this document. If you have received this fax in error please call 1.866.590.6703.

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

CGS®
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Originated October 3, 2025

PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION!

JURISDICTION 15 PART B OHIO

PRIOR AUTHORIZATION ASC: RHINOPLASTY

Please answer and follow the instructions for each question below.

QUESTIONS

Q1. Does the beneficiary have a nasal deformity associated with congenital anomaly? **Yes** ☐ **No** ☐ **Not Applicable** ☐

Comments:

Q2. Does the beneficiary have a deformity resulting in breathing difficulty? **Yes** ☐ **No** ☐ **Not Applicable** ☐

Comments:

Note: If you have answered No to both questions, procedure may not be considered medically necessary.

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

