

JURISDICTION 15 PART A AND PART B OHIO

IMPLEMENTATION OF WASTEFUL AND INAPPROPRIATE SERVICE REDUCTION
(WISER) MODEL PRIOR AUTHORIZATION

PAR 457

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

UTN

Place of Service

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

Requested CPT/HCPCS (max of 4)

Primary Diagnosis Code

Date of Service

FACILITY INFORMATION (HOPD/ASC) OR
GROUP PRACTICE INFORMATION (PHYSICIAN OFFICE/HOME SETTING)

Name

Fax Number

PTAN

Note: If submitting by fax, fax number is required.
The fax number must be the fax number of the Place of Service.

NPI

Note: Facility information should be the Place of Service.

BENEFICIARY INFORMATION (only one beneficiary per form)

Beneficiary Name

Medicare ID

Date of Birth (DOB)

ATTENDING/RENDERING PHYSICIAN INFORMATION

Physician Name

PTAN

NPI

Fax Number

Address

REQUESTOR INFORMATION

Requestor Name

Email

Date

Phone Number

Fax Number

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Fax to: 615.660.5300

Mail to: CGS
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Nashville, TN 37202

For additional information, please visit our website at:

Part A: <https://www.cgsmedicare.com/parta/pa/wiser.html>

Part B: <https://www.cgsmedicare.com/partb/pa/wiser.html>

