Repetitive, Scheduled Non-Emergent Ambulance Transports

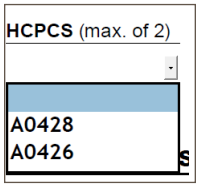
RSNAT Prior Authorization Request Form Instructions

The RSNAT prior authorization request form serves as a cover sheet for requesting a specified number of trips for a specified period of time. Ambulance suppliers can request up to 40 round trips (80 one-way trips) for a 60-day period. Complete the form in its entirety and submit with the appropriate documentation. Typed forms are easier to read and process faster versus handwritten forms.

Instructions

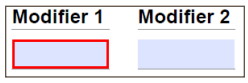
1. For each request, access the form on our website (https://www.cgsmedicare.com/pdf/j15/pa/rsnat_prior_auth_form.pdf), and type or select the required information in the PDF document.
2. **Request Type:** Select Initial (first request for services) or Resubmission (subsequest request to correct errors or omissions identified after receiving a non-affirmed decision or rejection.
   UTN: For resubmissions, provide the UTN assigned to the most recent request.

3. **HCPCS:** Select the appropriate HCPCS code(s) for the requested service(s): A0426 or A0428.

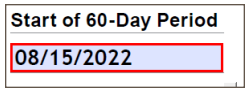


4. **Modifier 1 & 2:** Include the to and from destination modifiers for the transport.

   **These modifiers will attach to the UTN generated.*

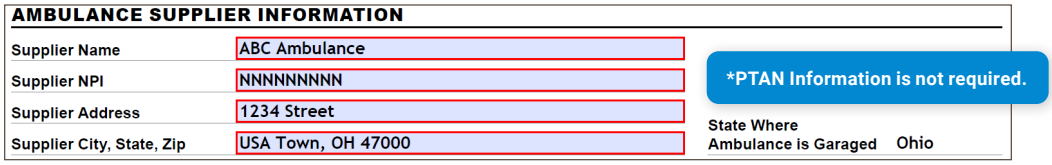


5. **Start of 60-Day Period:** Provide the actual date when services will begin (e.g., 08/15/2022). **DO NOT** write "August 2022" or "whenever I get approval."

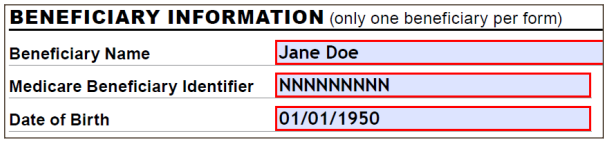


6. **Number of Transports Requested:** Indicate the number of transports requested for the 60-day period (maximum is 80 one-way trips in a 60-day period).

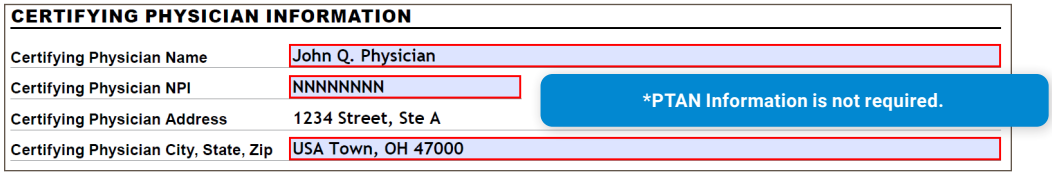
7. **Ambulance Supplier Information:** Type or clearly write in each field.



8. **Beneficiary Information:** Type or clearly write in each field.



9. **Certifying Physician Information:** Type or clearly write in each field.



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10. **Requestor Information:** Type or clearly write in each field. Be sure to provide a working/valid fax number.

REQUESTOR INFORMATION

Requestor Name	John Doe		
Email	john.doe@email_address.com		
Date	07/18/2020	**Fax number** (if a decision letter by fax requested)	(123) 456-7890
Phone Number	(123) 456-7890		

11. **Questions:** The questions on pages 2 and 3 provide guidance on documentation required for RSNAT transport. Complete all 8 questions. Any "No" response may result in services considered not reasonable and medically necessary.

QUESTIONS

Q1. Is a Provider Certification Statement (PCS) present? **Yes** ○ **or No** ○

Note: If answer is No, the service may not be considered reasonable and necessary due to insufficient documentation.

Comments:

12. Use the print button in the internet browser to print the completed form. **DO NOT** download or save the form to a local computer or drive for future use.

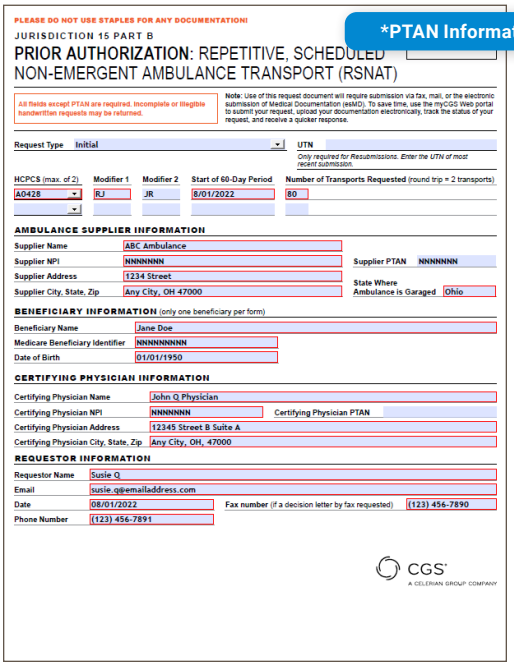
13. Submit the completed form and appropriate documentation by fax, mail, or esMD.

KY Fax: 1.615.664.5934
OH Fax: 1.615.664.5937
Mail to: CGS
PO Box 20203
Nashville, TN 37202

myCGS

The myCGS portal allows you to complete the form, attach documentation, and submit the RSNAT prior authorization request electronically. This option also allows you to receive a confirmation message, check the status of your request, and access the decision letter. See the myCGS User Manual (https://www.cgsmedicare.com/mycgs/ssi/forms/rsnat.html) for details.

Example of Completed Form (Initial)



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION!

JURISDICTION 15 PART B

PRIOR AUTHORIZATION: REPETITIVE, SCHEDULED NON-EMERGENT AMBULANCE TRANSPORT (RSNAT)

All fields except PTAN are required. Incomplete or illegible handwritten requests may 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: Initial | UTN: Only required for Resubmissions. Enter the UTN of most recent submission.

HCPCS (max. of 2)	Modifier 1	Modifier 2	Start of 60-Day Period	Number of Transports Requested (round trip = 2 transports)
A0428	RJ	JR	8/01/2022	80

AMBULANCE SUPPLIER INFORMATION

Supplier Name	ABC Ambulance		
Supplier NPI	NNNNNNN	Supplier PTAN	NNNNNNN
Supplier Address	1234 Street	State Where Ambulance is Garaged	Ohio
Supplier City, State, Zip	Any City, OH 47000		

BENEFICIARY INFORMATION (only one beneficiary per form)

Beneficiary Name	Jane Doe
Medicare Beneficiary Identifier	NNNNNNNNN
Date of Birth	01/01/1950

CERTIFYING PHYSICIAN INFORMATION

Certifying Physician Name	John Q Physician		
Certifying Physician NPI	NNNNNNN	Certifying Physician PTAN	
Certifying Physician Address	12345 Street B Suite A		
Certifying Physician City, State, Zip	Any City, OH, 47000		

REQUESTOR INFORMATION

Requestor Name	Susie Q		
Email	susie.q@emailaddress.com		
Date	08/01/2022	Fax number (if a decision letter by fax requested)	(123) 456-7890
Phone Number	(123) 456-7891		

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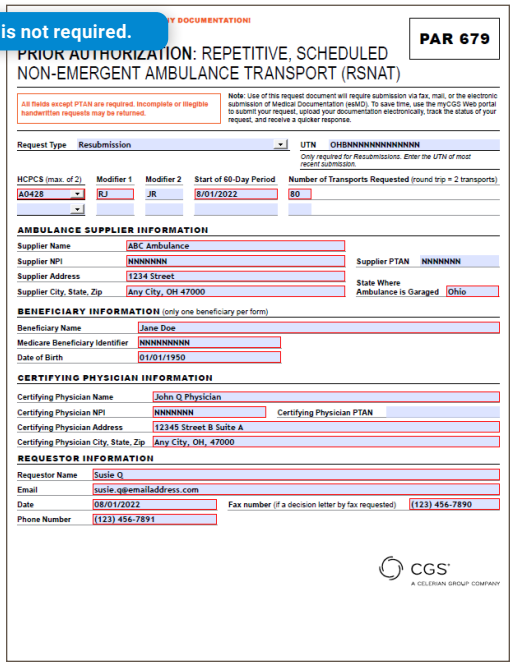
***PTAN Information is not required.**

Example of Completed Form (Resubmission)



PRIOR AUTHORIZATION: REPETITIVE, SCHEDULED NON-EMERGENT AMBULANCE TRANSPORT (RSNAT)

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All fields except PTAN are required. Incomplete or illegible handwritten requests may 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: Resubmission | UTN: OHBNNNNNNNNNNNNN | Only required for Resubmissions. Enter the UTN of most recent submission.

HCPCS (max. of 2)	Modifier 1	Modifier 2	Start of 60-Day Period	Number of Transports Requested (round trip = 2 transports)
A0428	RJ	JR	8/01/2022	80

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Certifying Physician NPI	NNNNNNN	Certifying Physician PTAN	
Certifying Physician Address	12345 Street B Suite A		
Certifying Physician City, State, Zip	Any City, OH, 47000		

REQUESTOR INFORMATION

Requestor Name	Susie Q		
Email	susie.q@emailaddress.com		
Date	08/01/2022	Fax number (if a decision letter by fax requested)	(123) 456-7890
Phone Number	(123) 456-7891		

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