

Condition of Payment Prior Authorization (PA) Program

JURISDICTION B

K0856, K0861 • Additional HCPCS as of 9/01/18: K0813-K0829, K0835-K0843, K0848-K0855

Request Date _____
For HCPCS _____
Entity Submitting Supplier Physician/Treating Practitioner (TP) _____
Supplier Name _____
Supplier Address _____

Supplier Phone _____
Supplier Contact Name _____
Supplier Fax _____
Supplier NPI _____
Supplier PTAN _____

Number of Pages (including coversheet) _____
Initial Request OR Subsequent Request _____

Physician/TP Name _____
Physician/TP Address _____

Physician/TP Phone _____
Physician/TP Fax _____
Physician/TP NPI _____

Beneficiary Name _____ Medicare Number _____
Beneficiary State of Residence _____ Beneficiary Date of Birth _____

Expedited Request? Yes No _____

Note: Expedited requests require justification to meet expedited requirements.

Expedited Request Justification _____

Checklist of PAR information to include:

- Completed coversheet
- 7-element order
- Face-to-Face assessment
- Detailed product description
- Specialty evaluation (if required by policy)
- Other relevant medical documentation

Fax the PAR to: 1.615.660.5992

OR

Mail to: CGS – JUR B DME Medical Review – Condition of Payment Program
PO Box 23110
Nashville, TN 37202-4890

For additional information, such as the medical policy, please visit our website at: https://www.cgsmedicare.com/jb/mr/power_mobility_resources.html

