



Wasteful and Inappropriate Service Reduction Prior Authorization Request Fax/Mail Cover Sheet

Complete all fields; attach supporting medical documentation and fax to **617-843-6857** or mail to the applicable address provided at the bottom of the page. Complete **ONE (1)** Medicare Fax/ Mail Cover Sheet for each prior authorization request for which documentation is being submitted.

| Required Information | | | | |
|---|---|---|---|--------------------|
| Beneficiary Last Name: | | Beneficiary First Name: | | |
| Medicare ID: | | Date of Birth (YYYY-MM-DD): | | |
| Rendering Provider/ Facility Name: | | Request Type: <input type="checkbox"/> Part A <input type="checkbox"/> Part B | | |
| Rendering Provider/ Facility Address: | | Place of Service <input type="checkbox"/> 11- Office <input type="checkbox"/> 24- ASC <input type="checkbox"/> 12- Home <input type="checkbox"/> TOB 13X | | |
| Rendering Provider/ Facility NPI: | Rendering Provider/ Facility CCN/PTAN: | | | |
| Ordering/Referring Physician Name: | | | | |
| Ordering/Referring Physician Address: | | | | |
| Ordering/Referring Physician NPI: | Ordering/Referring Physician CCN/PTAN: | Procedure Code | Site(s)/Level(s) | Unit(s) of Service |
| Request Type: <input type="checkbox"/> Initial | <input type="checkbox"/> Resubmission Enter UTN of most recent submission: | Procedure Code | Site(s)/Level(s) | Unit(s) of Service |
| Diagnosis Code: | Procedure Code | Site(s)/Level(s) | Unit(s) of Service | |
| Requestor Name: | | Requestor email address: | Requestor Fax Number: | |
| Anticipated Date of Service (YYYY-MM-DD): | Date Submitted (YYYY-MM-DD): | Jurisdiction: | Requestor Phone Number: | |
| Urgency Level: <input type="checkbox"/> Standard <input type="checkbox"/> Expedited <input type="checkbox"/> I certify this request can place the member's life or ability to regain maximum function in serious jeopardy. Please provide rationale for expedited processing: | | | | |
| Comments: (i.e. Change in Facility, Record updates for resubmission, etc.): | | | Number of Pages (including coversheet): | |

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Important: Dates must be in YYYY-MM-DD format. Any other format may lead to dismissal without review.

Send form to:

**HUMATA HEALTH
PO BOX 890092
CAMP HILL PA 17089-0092**

www.humatahealth.com

Clinical & Intake Help: wiser@humatahealth.com
General Support: wiser.support@humatahealth.com

Portal URL: <https://psi.humatahealth.com>