Please Do Not Copy

Humata Health

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: ☐ Part A ☐ Part B			
Rendering Provider/ Facility Address:	Place of Service ☐ 11- Office ☐ 24- ASC ☐ 12- Home ☐ TOB 13X			
Rendering Provider/ Facility NPI:	Rendering Provider/ Facility CCN/PTAN:	Rendering Provider Email Address:		
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: ☐ Initial ☐ 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 Fax Number:
Anticipated Date of Service ***(YYYY-MM-DD):***	Date Submitted ***(YYYY-MM-DD)*:**	Jurisdiction:	Requestor Phone Number:	
Urgency Level: ☐ Standard ☐ Expedited ☐ 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:				

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