



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:	Required 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:				

This document is intended solely for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this notice is not the intended recipient or individual responsible for delivering the message to the intended recipient, you are hereby advised that any dissemination, distribution or copying of this information is strictly prohibited. If you receive this communication in error, please advise us by telephone and destroy these papers.

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>