



Wasteful and Inappropriate Service Reduction Resubmission with Peer-to-Peer 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: ☐ Resubmission Enter UTN of most recent submission:		☐ Peer to Peer	Procedure Code	Site(s)/Level(s)
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:				

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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>