

Ambulatory Surgery Center (ASC) Prior Authorization Request

Facility Information

Beneficiary Information

Operating Physician Information

| | | |
|--|--|---|
| <p>Name* <input style="width: 100%; height: 20px;" type="text"/></p> <p>NPI* <input style="width: 100%; height: 20px;" type="text"/></p> <p>PTAN* <input style="width: 100%; height: 20px;" type="text"/></p> <p>State / Contract ID</p> <p><input type="radio"/> Georgia - 10212</p> <p><input type="radio"/> Tennessee - 10312</p> | <p>First Name* <input style="width: 100%; height: 20px;" type="text"/></p> <p>Last Name* <input style="width: 100%; height: 20px;" type="text"/></p> <p>Date of Birth* <input style="width: 20%; height: 20px;" type="text"/> / <input style="width: 20%; height: 20px;" type="text"/> / <input style="width: 20%; height: 20px;" type="text"/></p> <p>Medicare ID* <input style="width: 100%; height: 20px;" type="text"/></p> <p>Gender*</p> <p><input type="radio"/> Male</p> <p><input type="radio"/> Female</p> | <p>First Name* <input style="width: 100%; height: 20px;" type="text"/></p> <p>Last Name* <input style="width: 100%; height: 20px;" type="text"/></p> <p>NPI* <input style="width: 100%; height: 20px;" type="text"/></p> <p>PTAN* <input style="width: 100%; height: 20px;" type="text"/></p> <p>Address* <input style="width: 100%; height: 20px;" type="text"/></p> |
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Request Details

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| <p>Date of Service (DOS)* <input style="width: 20%; height: 20px;" type="text"/> / <input style="width: 20%; height: 20px;" type="text"/> / <input style="width: 20%; height: 20px;" type="text"/></p> <p><input type="checkbox"/> This is a resubmission. If yes, please provide UTN below. <input style="width: 100%; height: 20px;" type="text"/></p> <p><input type="checkbox"/> Is this life threatening? If yes, please explain below. <input style="width: 100%; height: 60px;" type="text"/></p> | <p>Primary Diagnosis Code* <input style="width: 100%; height: 20px;" type="text"/></p> <p>Secondary Diagnosis Code* <input style="width: 100%; height: 20px;" type="text"/></p> <p>Additional Diagnosis Code(s) <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/></p> |
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This form continues on page 2.

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Procedure Codes - Please select all procedure codes for this request.

Botox Number of Units Requested *(Required for Botox Requests)*
 64612 64615 J0585 J0586 J0587 J0588 J0589

Blepharoplasty
 15820 15821 15822 15823 67900 67901 67902 67903 67904 67906 67908

Panniculectomy
 15830 15877

Rhinoplasty
 20912 21210 30400 30410 30420 30430 30435 30450 30460 30462 30465 30520

Vein Ablation
 36473 36475 36478 36482 Staged Procedure

Requestor Information

Requestor Name* Requestor Phone*
() - ext

Requestor is a representative of the...* Ambulatory Surgical Center
 Physician/NPP Requestor Fax (only if faxed response is requested)
() -

Facility Fax (see note)
() -

Note: If the Requestor is a representative of the Operating or Attending Physician AND a faxed response is requested, the fax number for the Facility is required in addition to the Requestor's fax number.

Please send this form and all additional documentation to:

Mail
Palmetto GBA
Part B - Prior Authorization
PO BOX 100212
Columbia, SC 29202-3212

Fax
(803) 462-7313