Please Do Not Copy

53703

EXPEDITED

Prior Authorization Request Ambulatory Surgical Center (ASC) Procedures

Expedited Medicare Part B Fax/Mail Cover Sheet

Complete all fields; attach supporting medical documentation and fax to **855-815-3065** or mail to the applicable address/number 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:			
ASC Facility NPI:	ASC Facility CCN/PTAN:	ASC Facility Fax Number:			
ASC Facility Name and Address:					
Physician NPI:	Physician PTAN:	Physician Fax Number:			
Physician Name and Address:					
Requestor Name:		Requestor Email Address:			
Requestor Phone Number:		Procedure Code	Modifier ☐RT ☐LT	Site(s)/Level(s)	Unit(s) of Service
Requestor Fax Number:		Procedure Code	Modifier ☐RT ☐LT	Site(s)/Level(s)	Unit(s) of Service
Request Type: ☐ Initial ☐ Resubmission		Procedure Code	Modifier ☐RT ☐LT	Site(s)/Level(s)	Unit(s) of Service
Diagnosis Codes (esMD submission only):					
Anticipated Date of Service:		State (location) of Authorization: Select State		Date Submitted:	
Comments (i.e. Reason for Expedited Request, Change in ASC Facility, Record updates for resubmission, etc.)					

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.

FIRST COAST SERVICE OPTIONS
P.O. Box 3033
Mechanicsburg, PA
17055
medicare.fcso.com

Print Form Clear Form