PeakHealth

REQUEST FOR MEDICARE PRESERVICE AUTHORIZATION DETERMINATION

This form may be sent to us by mail or fax:

Address:
1085 Van Voorhis Road
Suite 300
Morgantown, WV 26505

Fax Number:
(304) 974-3191

You may also ask us for a coverage determination by phone at 1-855-962-7325 (TTY: 711)

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip
Phone:	Enrollee's Member ID #	

Complete the following section ONLY if the person making this request is not the enrollee or ordering physician:

Requestor's Name		Relationship to Enrollee
Address		
City	State	Zip
Phone:		

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber: Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written

equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

Name of service or durable medical equipment you are requesting (If known CPT code or HCPCS code, number of units, preferred servicing provider)

Additional information we should consider (attach any supporting documents):

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Important Note: Expedited Decisions: If you or your prescriber believe that waiting 14 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 14 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a service or medical equipment you already received.

☐ **REQUEST FOR EXPEDITED REVIEW**: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Signature:	Date: