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.

*Please note, all fields listed are **REQUIRED**. If all fields are not completed, it may delay processing the request.*

Enrollee's Information

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

Provider's Information

Requesting Provider's Name:	TIN/ NPI:	Provider Group (if applicable):
Requesting Provider's Address:		
Requesting Provider's Phone Number:	Requesting Provider's Fax Number:	
Service Provider or Facility Name:	Service Provider or Facility TIN/NPI:	

Service Provider or Facility's Address:	
Service Provider or Facility's Phone Number:	Service Provider or Facility's Fax Number:

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.

Date(s) of Service:	Planned Service or Procedure:
CPT/HCPCS/Service(s) and/or Drug(s) being requested (for drugs, please provide specific strengths, dosing, and quantities requested as well as administration codes):	
Diagnosis Code(s):	
Number of visits, frequency, and duration (if applicable):	
Previous therapy or medication trial(s) (if applicable):	

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

Important Note: Expedited Decisions: If you or your prescriber believe that waiting 7 days for a medical service or 72 hours for a Part B drug for a standard decision that 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 7 days for a medical service or 72 hours for a Part B drug for a standard decision 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 medication.

☐ **REQUEST FOR EXPEDITED REVIEW**: By checking this box and signing below, I certify that applying the 7-day standard review timeframe for a medical service or 72-hour standard review timeframe for a Part B drug may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Signature:	Date: