PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

PALMETTO GBA
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Prior Authorization Form

Fields with a red asterisk (*) are required

Request Type (Check One) * ◉ Initial ○ Resubmission ☐ Please expedite this request

If you selected "Expedited" above, please provide a reason *

Number of Transports Requested (Round Trip = 2 Transports) *

Ambulance Supplier / Provider Information

Provider Name *

National Provider Identifier (NPI) *

Provider Number (PTAN) *

Provider Address *

Provider City *

Provider State * Provider Zip *

State Where Ambulance is Garaged *

Beneficiary Information

Beneficiary First Name *

Beneficiary Last Name *

Health Insurance Claim (HIC) Number *

Beneficiary Date of Birth (mm/dd/yyyy) * / /

Beneficiary Gender * ○ Male ○ Female

A decision letter will be mailed to the address provided. If you would also like a faxed copy, please give your fax number below.

( ) -

Claim Information

Start of 60 Day Period (mm/dd/yyyy) * / /

Procedure Code * A0428

Modifier 1 *

Modifier 2

Certifying Physician Name *

Certifying Physician NPI *

Certifying Physician PTAN

Certifying Physician Address *

Certifying Physician City, State Zip *

Requestor Information

Requestor Name *

Requestor Phone Number & Extension * ( ) - x

Signature *

Date *

PA-JM-B-1000
Revised 08/2015

Please send this form and all additional documentation to
Fax: (803) 462-2702
P.O. Box 100212
Columbia, SC 29202-3212