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JURISDICTION L, NEW JERSEY

Prior Authorization Request for Wasteful and Inappropriate Service Reduction (WISeR) Model Medicare Part A Fax/Mail Cover Sheet

Complete all fields; attach supporting medical documentation, and fax or mail to the address 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.

Fields with a red asterisk (*) are required. Incomplete or Illegible handwritten requests will be returned.

Required Information		
Request Type*	Submission Type*	Previous UTN <i>Required if you selected Resubmission</i>
Place of Service*	Date of Service	Type of Bill*
Procedure Code(s)*	Modifier	Unit(s) of Service*
Procedure Code(s)*	Modifier	Unit(s) of Service*
Procedure Code(s)*	Modifier	Unit(s) of Service*
Diagnosis Codes:		
Facility Provider Information		
Facility Name*	Facility NPI*	Facility CCN*
Address Line 1*	Address Line 2	
Facility City*	Facility State*	Facility Zip*
Beneficiary Information		
Last Name*	First Name*	
Medicare ID*	Date of Birth*	
Ordering/Referring Physician Information		
Physician Name*	Physician NPI*	PTAN*
Physician Address*	City, State, Zip*	
Requester Information		
Requester Name*	Email*	
Requester Fax*	Phone*	Extension

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Fax to: 1 (484) 200-2155
Website: <https://portal.hip.one>
Mail to: Genzeon Corp., 256 Eagleview Blvd., Suite 509,
Exton, PA 19341



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