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JURISDICTION L, NEW JERSEY

GENZEON PLATFORMS

Prior Authorization Request for Wasteful and Inappropriate Service Reduction (WISeR) Model Medicare Part B 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 *Required if you selected Resubmission*	
Place of Service*		Date of Service	
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/Rendering Provider (ASC/Physician) Information			
Name*		NPI*	PTAN* .
Address Line 1*		Address Line 2	
City*		State*	Zip*
Beneficiary Information			
Last Name*		First Name*	
Medicare ID*		Date of Birth*	
Ordering/Referring Physician Information			
Physician Name*		NPI*	PTAN*
Physician Address*		City, St-ate, 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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