Condition of Payment Prior Authorization (PA) Program

JURISDICTION B

Expedited Request? ☐ Initial Request ☐ Resubmission Request ☐

Note: Expedited requests require justification to meet expedited requirements.

Request Date

Number of Pages (including coversheet)

For HCPCS

Entity Submitting Supplier ☐ Physician/Treating Practitioner (TP) ☐

Supplier Name

Physician/TP Name

Supplier Address

Physician/TP Address

Supplier Phone

Physician/TP Phone

Supplier Contact Name

Physician/TP Fax

Supplier Fax

Physician/TP NPI

Supplier NPI

Supplier PTAN

Beneficiary Name

Medicare Number

Beneficiary State of Residence

Beneficiary Date of Birth

For additional information such as medical policy, please visit our websites for:

- Power Mobility Devices: https://www.cgsmedicare.com/jb/mr/pmd_prior_auth.html
- Group II Pressure Reducing Support Surfaces: https://www.cgsmedicare.com/jb/mr/prsspa.html
- Lower Limb Prosthetics: https://www.cgsmedicare.com/jb/mr/llp_prior_auth.html

Please submit forms via the myCGS Web portal, esMD, fax, or mail.

Fax: 1.615.660.5992
Mail to: CGS – JUR B DME Medical Review – Condition of Payment Program
PO Box 23110
Nashville, TN 37202-4890

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CGS
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Basinger's Pharmacy

Basinger's Pharmacy Marycrest ,2130 W Jefferson St , Joliet, IL 60435 , Phone: (815)725-1102, Pharmacy Fax: (815)725-7500)

Medication Transfer Sheet/Release of Responsibility

Name of Facility: _____

Name of Resident: _____

_____

Date of Release: Expected Date of Return:

Name of Medication	Pass Time	RX Number	Strength	# of Meds Released	# of Meds Returned

Transferring medications for home visits, outings, etc. Taken from Community Care Licensing technical support program medications.

- When a consumer/resident leaves a facility for a short period of time during which only one dose of medication(s) is/are needed, the facility may give consumer/resident medications to a responsible person/authorized representative in an envelope (or similar container) labeled with the facility's name and address, consumer/resident's name, name of medication(s), and instructions for administering the dose.
- If consumer/resident is to be gone for more than one dosage period, the facility may:

a. Give the full prescription contained to the consumer/resident, or responsible person/authorized representative.

OR

b. Have the pharmacy fill a separate prescription or separate the existing prescription into two bottles.

OR

c. Have the consumer's/resident's family obtain a separate supply of the medication for use when the consumer/resident visits with the family.

The resident, and/or responsible party assumes responsibility for the resident and for assuring that all medication (if any) are taken appropriately, during the time the resident is signed out of the facility. The facility is not responsible for any accidents, illnesses or injury during this time. My signature indicates that I have received the above listed medications, and have been instructed in their use. I also agree to return any unused medications when the visit is concluded.

Signature of staff releasing medications: _____
Received by: _____ Date: _____ Time: _____
Signature of person returning unused medications: _____
Staff signature of count on return: _____ Date: _____ Time: _____