



## Wasteful and Inappropriate Service Reduction Resubmission with Peer-to-Peer Request

### Fax/Mail Cover Sheet

**Complete all fields;** attach supporting medical documentation and fax to **617-843-6857** or mail to the applicable 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.

Required Information				
Beneficiary Last Name:		Beneficiary First Name:		
Medicare ID:		Date of Birth (YYYY-MM-DD):		
Rendering Provider/ Facility Name:		Request Type: <input type="checkbox"/> Part A <input type="checkbox"/> Part B		
Rendering Provider/ Facility Address:		Place of Service <input type="checkbox"/> 11- Office <input type="checkbox"/> 24- ASC <input type="checkbox"/> 12- Home <input type="checkbox"/> TOB 13X		
Rendering Provider/ Facility NPI:	Rendering Provider/ Facility CCN/PTAN:			
Ordering/Referring Physician Name:				
Ordering/Referring Physician Address:				
Ordering/Referring Physician NPI:	Ordering/Referring Physician CCN/PTAN:	Procedure Code	Site(s)/Level(s)	Unit(s) of Service
Request Type: <input type="checkbox"/> Resubmission Enter UTN of most recent submission:	<input type="checkbox"/> Peer to Peer	Procedure Code	Site(s)/Level(s)	Unit(s) of Service
Diagnosis Code:		Procedure Code	Site(s)/Level(s)	Unit(s) of Service
Requestor Name:		Requestor Fax Number:		
Anticipated Date of Service (YYYY-MM-DD):	Date Submitted (YYYY-MM-DD):	Jurisdiction:	Requestor Phone Number:	
Urgency Level: <input type="checkbox"/> Standard <input type="checkbox"/> Expedited	<input type="checkbox"/> I certify this request can place the member's life or ability to regain maximum function in serious jeopardy. <input type="checkbox"/> Please provide rationale for expedited processing:			
Comments: (i.e. Change in Facility, Record updates for resubmission, etc.):			Number of Pages (including coversheet):	

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**Important: Dates must be in YYYY-MM-DD format. Any other format may lead to dismissal without review.**

Send form to:

**HUMATA HEALTH  
PO BOX 890092  
CAMP HILL PA 17089-0092**

**www.humatahealth.com**

Clinical & Intake Help: wiser@humatahealth.com  
General Support: wiser.support@humatahealth.com

Portal URL: <https://psi.humatahealth.com>