WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1-844-633-8427 OUTPATIENT SURGERY**

REGISTRATION ON C3 IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.
DETERMINATIONS ARE AVAILABLE ON HTTPS://PROVIDERPORTAL.KEPRO.COM

C3 Requesting/Submitting Organization _____ Please list exactly as registered on C3

Address, City, State, Zip _____

C3 Requesting/Submitting Organization NPI _____ Please list exactly as registered on C3

Person Submitting Request _____ **Phone** _____ **Fax** _____ **Email**_____

Referring/Ordering Provider

(Per policy the Referring/Ordering Provider must be actively enrolled with WV Medicaid)

Name Do not write "See Above"	**NPI Number**	
Contact Information	**Phone**	**Fax:**

Place of Service/Servicing Provider

(Per policy the Place of Service/Servicing Provider must be actively enrolled with WV Medicaid)

Name Do not write "See Above"	**NPI Number**
Address, City, State, Zip	

Member Medicaid Number _____ **DOB**_____

Member First Name _____ **Last Name** _____

Member Address, City, State, ZIP _____

Procedure Type: OP SURGERY **Type of Admission/Procedure:** ☐**Emergency/Medically Urgent** ☐**Non-Urgent**

Authorization Type:

☐**Prior Authorization**

☐**Retrospective Request, if applicable list the appropriate reason:**

☐**Denied by Member's Primary Payer** ☐**Retrospective Medicaid Eligibility**

List Other Retro Reason:

For Members under age 21, is this request an EPSDT referral? ☐**Yes** ☐**NO** **If yes, please submit the most current EPSDT form on file**

Place of Service:

☐**Office** ☐**Urgent Care Facility** ☐**Inpatient Hospital** ☐**OP Hospital** ☐**Ambulatory Surgical Center** ☐**Birthing Center** ☐**Military Treatment Facility**

LIST ALL RELEVANT ICD DIAGNOSIS CODE(S):

Primary DX: _____ Symptoms: _____

Other DX:

RELEVANT DIAGNOSTIC (LAB.IMAGING.RADIOLOGY) STUDIES PERFORMED

If you have relevant diagnostics that you would like to include please indicate such on this form or include as an attachment with the submission:

SERVICE START DATE: _____

****Please request the Primary service code for both the Referring/Rendering Provider and the Servicing Provider/Location/Facility****

1. **SURGICAL PROVIDER (PHYSICIAN) CPT CODE:** **Primary:**_____**Secondary:**_____

   LIST FACILITY/PLACE OF SERVICE FOR SURGERY: _____

2. **SURGICAL PROVIDER (PHYSICIAN) CPT CODE:** **Primary:**_____**Secondary:**_____

   LIST FACILITY/PLACE OF SERVICE FOR SURGERY: _____

3. **SURGICAL PROVIDER (PHYSICIAN) CPT CODE:** **Primary:**_____**Secondary:**_____

   LIST FACILITY/PLACE OF SERVICE FOR SURGERY: _____

DESCRIBE SURGICAL PROCEDURE(S) LISTED ABOVE:

*IF SURGICAL PROCEDURE IS BREAST-RELATED PLEASE INDICATE BRA SIZE (PRE-SURGERY)*_____

Does this admission follow observation? ☐**Yes** ☐**No** **Date Placed in Observation:** _____

If Yes, describe the progression of symptoms/illness plus treatment administered during observation:

Is this an Orthopedic Procedure? ☐**Yes** ☐**No** **If Yes, please provide description:**

Have NSAIDS been tried? ☐**Yes** ☐**No** *If yes, please mark duration* ☐0-3 months ☐3-6 months ☐6-9 months ☐12+ months ☐9-12 months

If yes list outcome, if no list why:

_____

Has activity modification been tried? ☐**Yes** ☐**No** *If yes, please mark duration* ☐0-3 months ☐3-6 months ☐6-9 months ☐12+ months ☐9-12 months

If yes list outcome including duration, if no list why:

_____

Please provide description of known *Medical History* and relation to request :

Is the member currently taking medication? ☐**Yes** ☐**No**

If yes, please attach a MAR showing name, strength, route, prescribed date, quantity and frequency