WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1.844-633-8431 VISION**

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 WVCHIP)

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 WVCHIP)

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

Member WVCHIP Number _____ **DOB**_____

Member First Name _____ **Last Name** _____

Member Address, City, State, ZIP _____

Authorization Type: ☐**Prior Authorization** **Place of Service: OFFICE**

☐**Retrospective WVCHIP Eligibility**

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

List Other Retro Reason:

Type of Admission/Procedure: ☐**Emergency/Medically Urgent** ☐**Non-Urgent** **Date of Last Vision Exam:** _____

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____

CPT CODE		POS: 11 OFFICE # of Units: 1 Start Date:_____/_____/_____
CPT CODE		POS: 11 OFFICE # of Units: 1 Start Date:_____/_____/_____
CPT CODE		POS: 11 OFFICE # of Units: 1 Start Date:_____/_____/_____

IF THIS IS A REPAIR OR REPLACEMENT REQUEST PLEASE ANSWER THE FOLLOWING QUESTION:

- **HAS VISUAL APPLIANCE BEEN REPAIRED OR REPLACED WITHIN THE PAST YEAR?** ☐**Yes** ☐**NO**
- **IF YES, PLEASE INDICATE HOW MANY TIMES VISUAL APPLIANCES HAVE BEEN REPAIRED OR REPLACED.**
  - **PLEASE INDICATE NUMBER OF TIMES:** _____

ADDITIONAL ANNOTATIONS: