WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date ______________________

FAX 1-844-633-8431 CHIROPRACTIC

REGISTRATION ON ATTREZO IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.
DETERMINATIONS ARE AVAILABLE ON https://portal.kepro.com/

ATTREZO Requesting/Submitting Organization ____ Please list exactly as registered on ATREZZO

Address, City, State, Zip ____

ATTREZO Requesting/Submitting Organization NPI ________________________________ Please list exactly as registered on ATTREZO

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** ____

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:

Request Type: ☐ **Initial** ☐ **Established**

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

Type of Admission/Procedure: ☐ **Emergency/Medically Urgent** ☐ **Non-Urgent** **Place of Service: Office**

List ICD Diagnosis Code(s):

Primary ICD DX: ____

Symptoms: ____

Other DX:

CPT/Service Code(s) Requested:

START DATE ____________________

______________ | ______________ | ______________ Are the physician orders for each code attached? ___Yes ___No

If No, please list why:

____

Patient Status: ☐**Established** ☐**New** **Period of Request:** ☐**30 Days** ☐**60 Days** ☐**90 Days**

OTHER CHIROPRACTIC SERVICE CODES REQUESTED:

Service Code	Description	POS Office	POS Clinic	Start Date	Number of Units
72020	X-Ray Exam of Spine				
72040	X-Ray Exam of Neck Spine				
72050	X-Ray Exam of Neck Spine				
72052	X-Ray Exam of Neck Spine				
72070	X-Ray Exam of Thoracic Spine				
72072	X-Ray Exam of Thoracic Spine				
72074	X-Ray Exam of Thoracic Spine				
72080	X-Ray Exam of Trunk Spine				
72100	X-Ray Exam of Lower Spine				
72110	X-Ray Exam of Lower Spine				
72114	X-Ray Exam of Lower Spine				
72120	X-Ray Exam of Lower Spine				
98940	Chiropractic Manipulation				
98941	Chiropractic Manipulation				
98942	Chiropractic Manipulation				

EVALUATION SUBJECTIVE COMPLAINTS

Limited Range of Motion: ☐Yes ☐No
If Yes: ☐*Mild* ☐*Moderate* ☐*Severe*

Numbness: ☐Yes ☐No
If Yes: ☐*Mild* ☐*Moderate* ☐*Severe*

Other: ☐Yes ☐No
List ____
If Yes: ☐*Mild* ☐*Moderate* ☐*Severe*

Pain: ☐Yes ☐No
If Yes: ☐*Mild* ☐*Moderate* ☐*Severe*

Tingling: ☐Yes ☐No
If Yes: ☐*Mild* ☐*Moderate* ☐*Severe*

Subluxations:
☐ Cervical ☐ Lumbar ☐ Thoracic ☐ Other
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Subluxation Notes:

Frequency of Visits: ☐Bi-Weekly ☐Monthly ☐Weekly ☐Other (Describe):

Explain Declining Frequency of Visits

History of Exacerbations

Objective Findings

Prognosis

Extenuating Circumstances

ACTIVITY MODIFICATIONS ☐**Yes** ☐**No**
If YES mark duration ☐0-3 Months ☐3-6 Months ☐6-9 Months ☐9-12 Months ☐12+ ***and list outcome, if NO list why:***

NSAIDS ☐**Yes** ☐**No**
If YES mark duration ☐0-3 Months ☐3-6 Months ☐6-9 Months ☐9-12 Months ☐12+ Months ***and list outcome, if NO list why:***