WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1-844-633-8430 HOME HEALTH**

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** _____

Service Type: **Home Health** **Request Type:** ☐**Initial** ☐**Established**

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****

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

Place of Service: ☐**Homeless Shelter** ☐**Home** ☐**Assisted Living** ☐**Group Home**

If Member is under age 18, are they enrolled in the Children with Special Health Care Needs Program? ☐**Yes** ☐**No**

List ICD Diagnosis Code(s):

Primary ICD DX: _____

Symptoms: _____

Other DX:

SERVICES REQUESTED

☐Physical Therapy	Units :	Planned Number of Visits:	Service Start Date:
☐Occupational Therapy	Units :	Planned Number of Visits:	Service Start Date:
☐Speech/Language Therapy	Units :	Planned Number of Visits:	Service Start Date:
☐Skilled Nursing Visit(s)	Units :	Planned Number of Visits:	Service Start Date:
☐Medical Social Works Services	Units :	Planned Number of Visits:	Service Start Date:
☐Home Health Aide Services	Units :	Planned Number of Visits:	Service Start Date:

*****Please complete the following if request if for an ESTABLISHED patient. *****

Patient's Current Condition: ☐Acute ☐Chronic ☐Long-Term ☐Long-Term Maintenance (condition is stable) ☐Terminal

Medical Necessity: **You may attach H&P or other relevant clinical documentation—if so, please write see attached**

Planned Interventions (Including Frequency):

Mental Status:

Caregiver Support Available: ☐Yes ☐No

If yes, Caregiver is available/willing to receive education necessary to provide services to the member? ☐Yes ☐No

If No, explain

Ventilator Dependent: ☐Yes ☐No Ventilator Hours per Day_____

Please answer the following questions regarding current treatment:

Intravenous Fluids/Medications: ☐Yes ☐No If Yes, Type_____Dose_____Duration_____Frequency_____

Enteral (Tube) Feedings: ☐Yes ☐No If, yes is this the sole source of nutrition? ☐Yes ☐No If yes, Type of Nutrition_____ Frequency _____

Oxygen: ☐Yes ☐No If yes, LPM _____ Hours per Day _____

Non-Ventilator Dependent Tracheostomy: ☐Yes ☐No

PLEASE INDICATE/INCORPORATE ALL ASSOCIATED MEDICATIONS, TREATMENTS, THERAPIES, PREVIOUS DIAGNOSTIC STUDIES, ETC., (TO INCLUDE THE RELATION, DURATION, OUTCOMES, ACTIVITY MODIFICATIONS):