WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1.844-633-8426 INPATIENT**

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** _____

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Service Type: ☐Inpatient Surgical ☐General/Acute ☐Organ Transplant **Place of Service: INPATIENT HOSPITAL LOS**

ADMISSION DATE: **DISCHARGE DATE:**

List Other Retro Reason:

Authorization Type:

☐**Prior Authorization**

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

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

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

The WV Bureau for Medical Services defines MEDICALLY URGENT as follows: A delay in services could seriously jeopardize 1. the life or health of the consumer; 2. the ability of the consumer to regain function; 3. in the opinion of a physician with knowledge of the consumer's condition, would subject the consumer to severe pain that cannot be adequately managed without care or treatment that is the subject of the case.

Type of Admission

☐Direct ☐Direct/Medically Urgent ☐Elective ☐Elective/Medically Urgent ☐Emergency
☐Non-Elective ☐Non-Elective/Medically Urgent ☐Transplant ☐Transplant/Medically Urgent ☐Emergency/Medically Urgent

Type of Unit

☐Coronary Care Unit ☐Medical/Surgical ☐Critical Care Unit ☐Neonatal Intensive Care Unit (NICU)
☐Intensive Care Unit (ICU) ☐Special Care Nursery ☐Intermediate Care ☐Telemetry ☐Other: _____

Does this admission follow observation? ☐Yes ☐No If yes, Date of Observation _____

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

List ICD Diagnosis Code(s):

Primary ICD DX: _____

Symptoms: _____

Other DX:

SERVICES REQUESTED:

1. **CPT CODE:** _____ **Description:** _____
2. **CPT CODE:** _____ **Description:** _____
3. **CPT CODE:** _____ **Description:** _____

Is this a Bariatric ☐**Yes**☐**No** ***For Panniculectomy CPT 15830 Procedures Weight Loss Ranges:*** ☐0-25 ☐26-50☐51-75 ☐76-100 ☐100-125 ☐125+

Is this a Breast Reduction? ☐**Yes** ☐**No** **If yes, please list current bra size**_____

Is this an Orthopedic Procedure? ☐**Yes** ☐**No**

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

If yes list outcome, if no list why:

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

If yes list outcome, if no list why:

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

FOR ORGAN TRANSPLANT ONLY

☐**Heart Transplant** ☐**Adult Liver** ☐**Bone Marrow** ☐**Pediatric Liver**

☐**Kidney** ☐**Left** ☐**Right**

☐**Pancreas/Kidney** ☐**Left** ☐**Right**

☐**Lung** ☐**Single** ☐**Double** ☐**Left** ☐**Right**

☐**Heart/Lung** ☐**Single** ☐**Double** ☐**Left** ☐**Right**

☐**Small Intestine**

☐**Cornea** ☐**Left** ☐**Right**

Is a second organ being transplanted? ☐**Yes** ☐**No** ***If YES, please select reason:***

☐**Primary organ defect caused damaged to a second organ and transplant of the primary organ will eliminate the disease**

☐**Damage to the second organ will compromise the outcome of the transplant of the primary organ**

Additional Notes for Organ Transplant:

Please Note: If supporting documentation will be sent by mail or fax, please send the H&P, labs, imaging and treatment pertinent to the current admission ONLY. Sending the patient's entire medical record can cause delays in the processing of your request.