

WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____

FAX 1.844-633-8429 ORTHOTICS/PROSTHETICS

REGISTRATION ON C3 IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.
DETERMINATIONS ARE AVAILABLE ON [HTTPS://PROVIDERPORTAL.KEPRO.COM](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/Service Provider (Per policy the Place of Service/Service 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: ORTHOTICS PROSTHETICS Place of Service: OFFICE

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**

Type of Admission/Procedure: Emergency/Medically Urgent Non-Urgent Request Type: New Repair Replacement

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____

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

Other DX: _____

CPT/Service Code Requested: _____ Number of Units _____ Start Date _____

Circle Approximate Length of Time Needed: Less than 1 month 01-03 months 04-06 months 07-09 months 10-12 months Greater than 12

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

CPT/Service Code Requested: _____ Number of Units _____ Start Date _____

Circle Approximate Length of Time Needed: Less than 1 month 01-03 months 04-06 months 07-09 months 10-12 months Greater than 12

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

Height: _____ Measurement Centimeters Inches

Weight: _____ Measurement Kilos Pounds BMI: _____

Date Last Examined by Practitioner _____

Functional Level: Level-0 Level-I Level-II Level-III Level-IV

JUSTIFICATION OF MEDICAL NECESSITY

Does Patient Have:

- Impaired Endurance Yes No
- Impaired Hearing Yes No
- Impaired Mobility Yes No
- Impaired Respiration Yes No
- Impaired Speech Yes No
- Impaired Vision Yes No
- Restricted Activity Yes No
- Skin Breakdown Yes No
- Require Assistance with ADL's Yes No

NOTES:

Does the Patient and/or Caregiver demonstrate:

- Willingness and ability to use equipment Yes No N/A
- Is item suitable for use in home? Yes No N/A

Justification of Medical Necessity:

Are Physician's Order(s) Signed, Dated, and Attached? Yes No Date of Order: _____

I certify that this patient meets the program eligibility criteria and that this equipment is a part of the course of treatment and is reasonable, medically necessary and is most cost effective and is not a convenience item for the recipient, family, attending practitioner or supplier. To my knowledge, the above information is accurate. Yes No

Have you attached the signed and dated Prescribing Practitioner Certification of Medical Necessity? Yes No

SUPPLIER/VENDOR INFORMATION

Supplier Name _____ Supplier NPI _____

Supplier Contact Name _____

Supplier Phone Number: _____ Supplier Fax Number: _____

Supplier Address: _____

Supplier City, State, Zip: _____