

WV MEDICAID PRIOR AUTHORIZATION FORM

FAX 1-844-633-8427 OUTPATIENT SURGERY

Today's Date _____

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: OP SURGERY Type of Admission/Procedure: Emergency/Medically Urgent Non-Urgent

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**

Place of Service:

Office Urgent Care Facility Inpatient Hospital OP Hospital Ambulatory Surgical Center Birthing Center Military Treatment Facility

LIST ALL RELEVANT ICD DIAGNOSIS CODE(S):

Primary DX: _____ Symptoms: _____
Other DX: _____

RELEVANT DIAGNOSTIC (LAB.IMAGING.RADIOLOGY) STUDIES PERFORMED

If you have relevant diagnostics that you would like to include please indicate such on this form or include as an attachment with the submission:

SERVICE START DATE: _____

****Please request the Primary service code for both the Referring/Rendering Provider and the Servicing Provider/Location/Facility****

1. SURGICAL PROVIDER (PHYSICIAN) CPT CODE: Primary: _____ Secondary: _____

LIST FACILITY/PLACE OF SERVICE FOR SURGERY: _____

2. SURGICAL PROVIDER (PHYSICIAN) CPT CODE: Primary: _____ Secondary: _____

LIST FACILITY/PLACE OF SERVICE FOR SURGERY: _____

3. SURGICAL PROVIDER (PHYSICIAN) CPT CODE: Primary: _____ Secondary: _____

LIST FACILITY/PLACE OF SERVICE FOR SURGERY: _____

DESCRIBE SURGICAL PROCEDURE(S) LISTED ABOVE:

IF SURGICAL PROCEDURE IS BREAST-RELATED PLEASE INDICATE BRA SIZE (PRE-SURGERY) _____

Does this admission follow observation? Yes No Date Placed in Observation: _____

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

Is this an Orthopedic Procedure? Yes No If Yes, please provide description:

Have NSAIDS been tried? Yes No If yes, please mark duration 0-3 months 3-6 months 6-9 months 12+ months 9-12 months

If yes list outcome, if no list why:

Has activity modification been tried? Yes No If yes, please mark duration 0-3 months 3-6 months 6-9 months 12+ months 9-12 months

If yes list outcome including duration, if no list why:

Please provide description of known *Medical History* and relation to request :

Is the member currently taking medication? Yes No
If yes, please attach a MAR showing name, strength, route, prescribed date, quantity and frequency