WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1-844-633-8429 CARDIAC REHAB**

REGISTRATION ON C3 IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.
DETERMINATIONS ARE AVAILABLE ON 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/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**_____

1

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:

Patient Status: ☐**New** ☐**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** ☐ **Independent Clinic** ☐**OP Hospital**

List ICD Diagnosis Code(s):

Primary ICD DX: _____ Symptoms: _____

Other DX:

CIRCLE Service Code(s) Requested:

START DATE_____

_____93797 # of units_____ **_____93798 # of units_____**

Mark all applicable for Initial Admission and supply Justification of Medical Necessity

	Acute Myocardial Infarction
	Angina Pectoris
	Cardiac Dysrhythmias
	Cardiomegaly
	Complication of Transplanted Organ; Heart
	Functional Disturbances Following Cardiac Surgery
	Heart Failure
	New Evidence of Ischemia or an exercise test including Thallium scan
	Old Myocardial Infarction
	Organ/Tissue replaced by other means; Heart
	Organ/Tissue replaced by other means; Heart Valve
	Other acute & subacute forms of Ischemic Heart Disease
	Other Diseases of Endochardium
	Other forms of Chronic Ischemic Heart Diseases
	Other Post Procedural States; Automatic Implantable Cardiac Defibrillator
	Other Post Procedural States; Percutaneous Transluminal Coronary Angioplasty Status
	Other Post Procedural States; Unspecified Cardiac Device
	Personal history of other Cardio Respiratory Problems; Exercise Intolerance with Pain; at rest; with less than ordinary activity; with ordinary activity

MEDICAL JUSTIFICATION:

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

Current Plan of Care:

FREQUENCY (# OF) SESSIONS/WEEKS_____ START DATE_____ END DATE_____

PLANNED INTERVENTION/TREATMENTS-EXERCISE TRAINING DURATION:

☐**20 Minutes** ☐**40 Minutes** ☐**60 Minutes** ☐ **LIST Other: _____**

PLANNED INTERVENTIONS/TREATMENTS EXERCISE/TRAINING SESSION (Check all applicable)

☐ECG/EKG Monitoring during exercise
☐ECG/EKG rhythm strip with interpretation & physician revision of the exercise program
☐Limited physician follow-up to adjust medication or other treatment(s) related to program

EXPECTED GOAL (Check all applicable)

☐Improve blood cholesterol levels ☐Improve psychosocial well-being
☐Increase exercise tolerance ☐Reduce Mortality ☐Reduce symptoms of chest pain/shortness of breath