

WV MEDICAID PRIOR AUTHORIZATION FORM

FAX 1-844-633-8431 CHIROPRACTIC

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 _____

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: Office

List ICD Diagnosis Code(s):
Primary ICD DX: _____
Symptoms: _____
Other DX: _____

CPT/Service Code(s) Requested:	START DATE _____
_____ _____ _____	Are the physician orders for each code attached? ___Yes ___No
	If No, please list why: _____

OTHER CHIROPRACTIC SERVICE CODES REQUESTED:

Service Code	Description	POS Office	POS Clinic	Start Date	Number of Units
72010	X-Ray Exam of Spine				
72020	X-Ray Exam of Spine				
72040	X-Ray Exam of Neck Spine				
72050	X-Ray Exam of Neck Spine				
72052	X-Ray Exam of Neck Spine				
72069	X-Ray Exam of Trunk Spine				
72070	X-Ray Exam of Thoracic Spine				
72072	X-Ray Exam of Thoracic Spine				
72074	X-Ray Exam of Thoracic Spine				
72080	X-Ray Exam of Trunk Spine				
72090	X-Ray Exam of Trunk Spine				
72100	X-Ray Exam of Lower Spine				
72110	X-Ray Exam of Lower Spine				
72114	X-Ray Exam of Lower Spine				
72120	X-Ray Exam of Lower Spine				
98940	Chiropractic Manipulation				
98941	Chiropractic Manipulation				
98942	Chiropractic Manipulation				

EVALUATION SUBJECTIVE COMPLAINTS

Limited Range of Motion: Yes No
If Yes: Mild Moderate Severe

Numbness: Yes No
If Yes: Mild Moderate Severe

Other: Yes No
 List _____
If Yes: Mild Moderate Severe

Pain: Yes No
If Yes: Mild Moderate Severe

Tingling: Yes No
If Yes: Mild Moderate Severe

Subluxations:
 Cervical Lumbar Thoracic Other _____
 Subluxation Notes:

Frequency of Visits: Bi-Weekly Monthly Weekly Other (Describe): _____

Explain Declining Frequency of Visits

History of Exacerbations

Objective Findings

Prognosis

Extenuating Circumstances

ACTIVITY MODIFICATIONS Yes No
If YES mark duration 0-3 Months 3-6 Months 6-9 Months 9-12 Months 12+ *and list outcome, if NO list why:*

NSAIDS Yes No
If YES mark duration 0-3 Months 3-6 Months 6-9 Months 9-12 Months 12+ Months *and list outcome, if NO list why:*