

# WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date \_\_\_\_\_

FAX 1.844-633-8431 SPEECH

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)

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>
<b>Contact Information</b>	<b>Phone</b> _____ <b>Fax:</b> _____

**Place of Service/Service Provider** (Per policy the Place of Service/Service Provider must be actively enrolled with WV Medicaid)

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>
<b>Address, City, State, Zip</b>	

Member Medicaid Number \_\_\_\_\_ DOB \_\_\_\_\_

Member First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Member Address, City, State, ZIP \_\_\_\_\_

Authorization Type:  Prior Authorization  
 Retrospective Request, if applicable list the appropriate reason:  
 Denied by Member's Primary Payer  Retrospective Medicaid Eligibility

<b>List Other Retro Reason:</b>   
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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 Procedure:  Emergency/Medically Urgent  Non-Urgent PATIENT STATUS:  New  Established

<b>List ICD Diagnosis Code(s):</b>  Primary ICD DX: _____  Symptoms: _____  Other DX: _____
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**\*\*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

Please attach *Certificate of Medical Necessity* or appropriate documentation including signatures.

<b>Service Code:</b>	<b>Service Code:</b>	<b>Service Code:</b>
<b>Place of Service:</b> <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Public Health Clinic <input type="checkbox"/> Rural Health Clinic	<b>Place of Service:</b> <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Public Health Clinic <input type="checkbox"/> Rural Health Clinic	<b>Place of Service:</b> <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Public Health Clinic <input type="checkbox"/> Rural Health Clinic
<b>Units:</b>	<b>Units:</b>	<b>Units:</b>
Period of Request: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days	Period of Request: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days	Period of Request: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days
Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly	Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly	Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly
Duration of Individual Therapy Services: <input type="checkbox"/> 1 hour <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Event	Duration of Individual Therapy Services: <input type="checkbox"/> 1 hour <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Event	Duration of Individual Therapy Services: <input type="checkbox"/> 1 hour <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Event

**Declining Frequency Explanation:**

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<b>REQUIRED WITH EACH SPEECH REQUEST</b>		<b>ATTACHED?</b>
<b>Certificate of Medical Necessity</b>	<b>Date of CMN</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<b>Signed Physician's Order(s)</b>	<b>Date of Order</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Most Recent Progress Notes</b>	<b>Date of Notes</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Waiver Letter for School-Aged Children</b>	<b>Date of Letter</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<b>Treatment Care Plan</b>	<b>Date of TCP</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Members &lt;21 Individual Education Plan</b>	<b>Date of IEP</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<b>Progress Notes for Past Treatments</b>	<b>Date of PN</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Short and Long Term Goals</b>	<b>Date of Goals</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

*For renewal of speech services progress notes and new goals are always required.*

**NOTES:**