WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1.844-633-8431 AUDIOLOGY**

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** _____

Member Address, City, State, ZIP _____

Procedure Type: **AUDIOLOGY** **PATIENT STATUS:** ☐**New** ☐**Established**

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:

Type of Hearing Loss: ☐Conductive ☐Mixed ☐Sensorineural

Severity of Hearing Loss:

Left Ear ☐No Hearing Impairment ☐Mild 25-40 dB HL ☐Moderate 41-70 dB HL ☐Severe 71-90 dB HL ☐Profound >91 dB HL dB

Right Ear ☐No Hearing Impairment ☐Mild 25-40 dB HL ☐Moderate 41-70 dB HL ☐Severe 71-90 dB HL ☐Profound >91 dB HL dB

SERVICE SELECTION

Service Code:	Service Code:	Service Code:
Units:	Units:	Units:
Period of Request: ☐30 Days ☐60 Days ☐90 Days	Period of Request: ☐30 Days ☐60 Days ☐90 Days	Period of Request: ☐30 Days ☐60 Days ☐90 Days
Frequency: ☐Weekly ☐Biweekly ☐Monthly	Frequency: ☐Weekly ☐Biweekly ☐Monthly	Frequency: ☐Weekly ☐Biweekly ☐Monthly
Duration of Individual Therapy Services: ☐1 hour ☐15 Minutes ☐30 Minutes ☐Event	Duration of Individual Therapy Services: ☐1 hour ☐15 Minutes ☐30 Minutes ☐Event	Duration of Individual Therapy Services: ☐1 hour ☐15 Minutes ☐30 Minutes ☐Event

Declining Frequency of Visits Explanation: _____

If Member is under age 21, does member have an Individual Education Plan (IEP) that includes these services? ☐Yes ☐No If yes, please attach a copy.

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.

Medical History: Please include prior use of hearing aids and other intervention services. ***You may include clinical documentation—write see attached***

_____

Date of Medical Examination:_____(***INCLUDE ALL RELEVANT DIAGNOSTIC STUDY RESULTS, MEDICATIONS, EXAM FINDINGS)***

Medical Examination Findings:

_____

Date of Most Recent Audiological Evaluation (Required): _____ **Attached?** ☐**Yes** ☐**No**

Date of Most Recent Audiologist Treatment Care Plan (Required): _____ **Attached?** ☐**Yes** ☐**No**

Date of Most Recent Signed/Dated Physician Order (Required): _____ **Attached?** ☐**Yes** ☐**No**

Have you attached the required COST INVOICE and COST CALCULATION FORM if selecting a hearing aid code? ☐**Yes** ☐**No**

Date of Cochlear Implant Placement:_____
Reason for Cochlear Implant Replacement

Date of Cochlear Implant Repair: _____
Reason for Cochlear Implant Repair

PLEASE PROVIDE AUDIOLOGY DEVICE INFORMATION:

Make/Model: _____ Expiration Date : _____

Date of Placement: _____ Success: _____

Date of Warranty: _____ _____

NOTES: