

# WV MEDICAID PRIOR AUTHORIZATION FORM

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

FAX 1.844-633-8431 VISION =>21

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      Place of Service: OFFICE  
 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 Admission/Procedure:  Emergency/Medically Urgent     Non-Urgent      Date of Last Vision Exam: \_\_\_\_\_

<b>List ALL Relevant ICD Diagnosis Code(s):</b>
Primary DX: _____ Symptoms: _____

92002	<u>Eye Exam &amp; Treatment Initial New Patient</u>	POS: 11 OFFICE # of Units: 1 Start Date: ____/____/____
92004	<u>Eye Exam &amp; Treatment Comprehensive New Patient</u>	POS: 11 OFFICE # of Units: 1 Start Date: ____/____/____
92012	<u>Eye Exam &amp; Treatment-Intermediate-Established Patient</u>	POS: 11 OFFICE # of Units: 1 Start Date: ____/____/____
92014	<u>Eye Exam &amp; Treatment-Comprehensive-Established Patient</u>	POS: 11 OFFICE # of Units: 1 Start Date: ____/____/____
92018	<u>Eye Exam &amp; Evaluation-Anesthesia-Complete</u>	POS: 11 OFFICE # of Units: 1 Start Date: ____/____/____
92019	<u>Eye Exam &amp; Evaluation-Anesthesia-Limited</u>	POS: 11 OFFICE # of Units: 1 Start Date: ____/____/____

If This Is A Repair Or Replacement Request Please Answer The Following Question:

- Has Visual Appliance Been Repaired Or Replaced Within The Past Year?  Yes  No
- If Yes, Please Indicate How Many Times Visual Appliances Have Been Repaired Or Replaced.
  - Please Indicate Number Of Times: \_\_\_\_\_

<b>ADDITIONAL ANNOTATIONS:</b>
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