

# WV MEDICAID PRIOR AUTHORIZATION FORM

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

FAX 1-844-633-8430 HOSPICE

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/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:

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: \_\_\_\_\_

**List ICD Diagnosis Code(s):** Primary ICD DX: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Is the prognosis for primary diagnosis a terminal with life expectancy of less than six months? Yes \_\_\_\_\_ No \_\_\_\_\_

Other Dx: \_\_\_\_\_

ELECTION:  Election 1  Additional Election 1 Inpatient Stay  
 Election 2  Additional Election 2 Inpatient Stay  
 Election 3  Additional Election 3 Inpatient Stay  
 Election 4  Additional Election 4 Inpatient Stay  
 Subsequent Election  
 Additional Subsequent Election Inpatient Stay

Election Effective Date:

Service Code:  Routine Home Care Units \_\_\_\_\_  
 Continuous Home Care Units \_\_\_\_\_  
 Inpatient Respite Care Units \_\_\_\_\_  
 Inpatient Facility Care Units \_\_\_\_\_  
 Nursing Facility Reimbursement Units \_\_\_\_\_

**FOR NURSING FACILITY REIMBURSEMENT (658) ONLY**

Nursing Home: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Site of Service Provision  Community/Home  Hospice Facility  Inpatient Facility  Nursing Home